लैंगिक छळ झालेल्या व्यक्तींची वैद्यकीय
तपासणी करण्यासंदर्भात मार्गदर्शक सुचना.

महाराष्ट्र शासन
सार्वजनिक आरोग्य विभाग
शासन परिपत्रक क्रमांकः संकिर्ण - २०१४ /प्र.क्र.२७०/आरोग्य-३

१० वा मजला, संकुल इमारत,
गो.ते.रुग्णालय, मुंबई-४०० ००१.
तारीखः ०७ ऑगस्ट,२०१५

संदर्भ-

शासन परिपत्रक, सार्वजनिक आरोग्य विभाग, क्र. -संकिर्ण २०१३/प्र.क्र.५५/आरोग्य -३, दिनांक- १०.०५.२०१३

शासन परिपत्रक-

मा.उच्च न्यायालय,मुंबई खंडपीठ, नागपूर येथे दाखल याचिका क्रमांक ४६/२०१०, डॉ.रंजना पारधी विरुध्द महाराष्ट्र शासन मध्ये लैंगिक छळ झालेल्या स्त्रीयांची वैद्यकीय तपासणी करतांना राज्यात सुसुत्रता आणण्यासाठी मा.न्यायालयाने दिलेल्या निर्देशानुसार उपरोक्त संदर्भाधीन परिपत्रकान्वये मार्गदर्शक सूचना तयार करुन त्या अशा प्रकारची न्याय वैद्यक प्रकरणे हाताळण्यास सक्षम असलेल्या सर्व वैद्यकीय अधिका-यांना वितरीत करण्यात आल्या आहेत. तद्नंतर मा.सर्वोच्च न्यायालयाच्या निर्देशानुसार अशाच प्रकारच्या मार्गदर्शक सूचना केंद्र शासनाने पाठविल्या असून सर्व राज्यांत एकच मार्गदर्शक सूचना असाव्यात असे कळविले आहे. यास्तव, उपरोक्त संदर्भाधीन दिनांक १० मे, २०१३ चे परिपत्रक रद्द करण्यात येत आहे.

२. आता, या परिपत्रकान्वये केंद्र शासनाच्या मार्गदर्शक सूचनांची पुस्तिका सोबत जोडली असून ही मार्गदर्शक पुस्तिका कार्यरत असणा-या आणि न्याय वैद्यक प्रकरणे हाताळण्यास सक्षम असलेल्या सर्व वैद्यकीय अधिका-यांच्या निदर्शनास आणून देण्यात याव्यात आणि या पुस्तिकेमध्ये निर्देशित केल्याप्रमाणे अशा प्रकारची प्रकरणे हाताळणे बंधनकारक असल्याचे संबंधितांना सुचीत करण्यात यावे.

सदर शासन परिपत्रक महाराष्ट्र शासनाच्या www.maharashtra.gov.in या संकेतस्थळावर उपलब्ध करण्यात आला असून त्याचा संकेताक २०१५०७१३१२४८४५५६१७ असा आहे. हा आदेश डिजीटल स्वाक्षरीने साक्षांकित करुन काढण्यात येत आहे.

महाराष्ट्राचे राज्यपाल यांच्या आदेशानुसार व नावाने.

Shekhar Vasantrao Dhawale

Digitally signed by Shekhar Vasantrao Dhawale
DN: CN = Shekhar Vasantrao Dhawale, C = IN, S = Maharashtra, O = Government Of Maharashtra, OU = Deputy Secretary
Date: 2015.08.07 15:12:35 +05'30'

शेखर ढवळे
उपसचिव, महाराष्ट्र शासन

प्रत,
मा.मंत्री (आरोग्य) यांचे खाजगी सचिव.
मा.राज्यमंत्री (आरोग्य) यांचे खाजगी सचिव.
सचिव, वैद्यकीय शिक्षण व औषधी द्रव्य विभाग, मंत्रालय,मुंबई.
प्रधान सचिव, नगर विकास विभाग, मंत्रालय,मुंबई.
सचिव (कायदा व सुव्यवस्था) गृह विभाग, मंत्रालय, मुंबई.
सचिव, महिला व बाल विकास विभाग, मंत्रालय, मुंबई.
महासंचालक व पोलिस महसनिरीक्षक, महाराष्ट्र राज्य, मुंबई.
महासंचालक, गुन्हे व अन्वेषण विभाग, पुणे.
संचालक, आरोग्य सेवा, मुंबई.
संचालक, वैद्यकीय शिक्षण संचालनालय, मुंबई.
संचालक, न्यायसहाय्यक वैज्ञानिक प्रयोगशाळा.
प्राध्यापक आणि विभाग प्रमुख,न्यायवैद्यक शास्त्र, ग्रँड मेडीकल कॉलेज, मुंबई.
प्राध्यापक आणि विभाग प्रमुख,स्त्री रोग शास्त्र, ग्रँड मेडीकल कॉलेज, मुंबई.
समन्वयक,सेहत (CEHAT), मुंबई.
समन्वयक, (UNFPA), मुंबई.
सर्व सहसंचालक, आरोग्य सेवा.
सर्व उपसंचालक, आरोग्य सेवा.
सर्व जिल्हा शल्य चिकित्सक.
सर्व जिल्हा आरोग्य अधिकारी.
सार्वजनिक आरोग्य विभाग (सर्व कार्यासने)
निवडनस्ती (आरोग्य-३).

Ministry of Health
& Family Welfare
Government of India

सत्यमेव जयते

GUIDELINES & PROTOCOLS

Medico-legal care for survivors/victims of Sexual Violence

GUIDELINES & PROTOCOLS

Medico-legal care for survivors/victims of sexual violence

FOREWORD

I deem it a great honour to contribute this foreword to the Guidelines and Examinations Proformae for Medico Legal Cases of victims of sexual violence, being brought out under the auspices of the Ministry Of Health and Family Welfare, Government of India. With the publication of this compact document a long felt need to bring about a certain degree of uniformity in approaching, treating and documenting cases of sexual violence, mainly against women and girls should get fulfilled. Even so, there still maybe some gaps in these guideline which need to be plugged and through feedback received from various quarters further improvements can be effected in them. Thus, the exercise of drawing up these guidelines has to be treated as an iterative one and the process would need to continue till such time as a reasonable level of definitiveness can be brought into them.

The guidelines, have specially been drawn up for rape cases, although they could be used in other cases of sexual violence as well. Statistics pertaining to sexual and physical violence against women in this country are alarming as around one in three is likely to face this sort of violence in her lifetime. Thirty three percent plus is a big number while the approach to mitigating such problems has to be a holistic one cutting across boundaries. We in this Ministry have taken the first step towards sexual violence mitigation.

The guidelines are essentially aimed at doctors who might one day be called upon to handle female victims of sexual assault / rape in the course of their duty whether in a government hospital or even a private one. Sexual assault victims cannot be denied treatment in either of these hospitals when they approach them as denial has lately been made a cognizable criminal offence punishable with appropriate jail terms or fines or both. As is known rape law has been made more stringent with zero tolerance for offenders and through these guidelines the aim is to ensure a sensitive and humane approach to such victims, their proper treatment apart from attending or treating doctors responsibility and duty in recording and documenting the medical aspects in order that such cases when they come up before the criminal justice system are not found wanting in the quality of evidence produced by the prosecution during trial.

Many a times it has been experienced in the past in such cases that medical evidence has not been recorded and documented in a proper fashion leading thereby to a poor conviction in rape cases.

We are in debted to Justice Verma, who was the first one to highlight the need to standardize medical evidence collection during such victim's treatment process. This Ministry responded to the challenge and took the initiative in drawing up these guidelines. Here I would like to specifically mention the contribution made by my predecessor, Shri. Keshav Desiraju, the then Secretary/ Health and Family welfare, who realizing the gravity of this issue, responded to the challenge and expeditiously set up a committee for framing these guidelines in a time bound manner. We are deeply indebted to him for his personal intervention, indulgence and guidance at every stage of framing these guidelines.

Many persons from the medical, legal and administrative fields who have distinguished themselves in their professions have been associated with the work on these guidelines. Had it not been for their painstaking and dedicated effort these guidelines might not have either seen the light of day or may not have turned out to be so comprehensive and

complete. While it is difficult in the space allocated to me to pen down the names of all such individuals, it would suffice if a few of them were to be named. First and foremost, I would like to thank Ms. Padma B. Deosthali, Coordinator, CEHAT, Ms. Aruna Kashyap, Women's Rights Division, HRW, Ms. Vrinda Grover, Advocate, New Delhi, Ms. Indira Jaisingh, ASG, Professor Shekhar Sheshadri, Psychiatrist, NIMHANS, and Dr. Jagadeesh Reddy, Forensic Medicine Expert, Bengaluru.

I would also thank the Department of Health Research for their assistance in the formulation of the medical protocols, and the Ministry of Home Affairs for their kind support. The DGHS and his team of doctors who have contributed to this laudable effort in formulating the medical investigating protocol, while taking into consideration the concerns and suggestions of the Justice Verma Committee Report in Chapter 11; its conclusion recommendations and the appendix 7 of the report. A reference of the Ministry of Women and Child Development on the Child/patient interviewing and the sensitivities of forensic evidence collections that has been consulted needs a special mention, a sincere attempt to incorporate the psychological and social factors of the sexual assault survivor/victim, who could be a minor / child, as the case may be, have been drawn from the guidelines of Ministry of Women & Child Development. The responsibilities on the surrounding adults and the hospital staff have been articulated in such guidelines.

I would specially like to put on record my gratitude for Ms. Indira Jaisingh, Additional Solicitor General who has played a key role and contributed extensively to making its content pointed and effective.

I would also like to put on record my appreciation for the coordination and organisational efforts put in by Mrs. Shakuntala D. Gamlin, Joint Secretary, Ministry of Health & Family Welfare and her team comprising Shri Vikas Arya, Director, Shri Amal Pusp, Director, Smt. Aparna Sharma, Director, Shri Sanjay Pant, Under Secretary and staff from the Hospital Section. This team under the leadership of Shri C.K. Mishtra, Additional Secretary (H) has worked hard in putting together these guidelines.

The guidelines are to be brought to the attention of hospitals within the jurisdiction of each state and UT. It is incumbent on every government hospital in the country to treat rape victims free of charge, even post treatment will have to be gratis. Through this document I would like to avail the opportunity of appealing to every private hospital in the country to treat rape victims free of charge too as a part of their corporate social responsibility. In doing so they would be contributing to make India a better and safe place to live in. I'm sure these guidelines will be helpful to all the medical practitioners to deal with such cases in an informed manner.

The guidelines are being uploaded on the Ministry's website for information of all concerned and with the request that suggestions for their further improvement may be sent to Director (H), Ministry of Health and Family Welfare, Nirman Bhawan, New Delhi.

Dated 19 March, 2014
New Delhi

Mr Lov Verma
Secretary (HFW)

Message from WHO Representative to India

Violence is preventable and is not inevitable. There is a need to address the economic and sociocultural factors that foster a culture of violence against women (VAW). While we recognize that there is a need to adopt a multi-sectoral framework of mutually reinforcing interventions for prevention and management of gender based violence particularly against women and girls, the focus of our work is to build health systems capacities. The health care system is the only institution that interacts with almost every woman at some point in her life and women living with violence are likely to visit health facilities more frequently than non-abused women. Interventions by health providers can potentially mitigate both the short and long-term health effects of gender-based violence on women and their families.

Taking into understanding the rise in the reported cases of violence against women and also the gaps in responding to the needs of survivors of sexual violence at various levels, the Ministry of Health and Family Welfare is committed to setting up of standardized protocols for care, treatment and rehabilitative services for survivors of sexual violence. These guidelines and protocols recognize the role of the health sector and is a positive way forward towards providing empathetic support and rebuilding lives after assault.

WHO will continue to play a significant role in generating evidence of the health consequences of VAW, build health systems capacity and partner with other sectors to adapt an integrated approach in addressing this public health issue.



Dr Nata Menabde
WHO Representative to India

No.Z.28015/21/2013-H

Government of India
Ministry of Health & Family Welfare
Department of Health & Family Welfare
Hospital Division

Nirman Bhawan, N. Delhi
Dated the 18th March, 2013

ORDER

A Committee is constituted under the Chairmanship of Shri Keshav Desiraju, Secretary (H&FW), to go into all M/o Health & Family Welfare's related aspects related to the survivors/victims of sexual violence and sexual assault arising out of the Justice Verma Committee Report, particularly, with reference to standardizing the medical examination protocols for them.

2. The Committee will function under the Chairmanship of Shri Keshav Desiraju, Secretary (H&FW) with the following members:-

i) AS (H) & MoHFW
ii) Joint Secretary (Hospitals), MoHFW
iii) Ms. Vrinda Grover, Lawyer & Independent Researcher
iv) Ms. Aruna Kashyap, Asia Researcher, Women's Rights Division, Human Rights Watch
v) Dr. Suneeta Mittal, formerly of AIIMS
vi) Dr. Shekhar Sheshadri, Psychiatrist and Prof. NIMHANS
vii) Dr. Padma Deosthali, Coordinator of CEHAT
viii) Dr. Jagadeesh Reddy, Forensic medicine expert
ix) Ms. Indira Jaisingh, Lawyer
x) Ms. Renu Khanna (SAHAJ)
xi) Dr. T.S. Sidhu, formerly MS, RML Hospital
xii) Dy. Director General (Planning), Dte.GHS ----- Member Secretary

3. Terms of Reference of the Committee:-

The Terms of Reference of the Committee are the following:-

I) To finalise the revised 'Proformae' regarding 'Medical Examination Report for Sexual Assault Victim' and related guidelines for examination of such victims as drafted by DGHS.
ii) To examine the relevant observations/recommendations made by the Justice (Retd.) Verma Committee Report for effective and time bound implementation.
iii) To examine the relevant observations/recommended measures from the Minutes of meeting dated 4th January, 2013 of the Chief Secretaries and Director Generals of Police for effective and time bound implementation.
iv) To examine the relevant observations/recommended measures from the meeting dated 23rd January, 2013 of Committee of Secretaries held under the Chairmanship of Cabinet Secretary for effective and time bound implementation.
v) To finalise M/o H&FW's views on the draft manuals developed for addressing sexual violence by Indian Council of Medical Research (ICMR)

vi) Any other related matter as desired by Chairman to be placed before the Committee.

4. The Committee may co-opt other members as per requirement.

5. This issues with the approval of Secretary (H&FW).

Sd/-
(Sanjay Pant)
Under Secretary to the Govt. of India
Tel: 011-23061521

Copy for information to:

1. All Members of the Committee
2. DGHS/DD(P), Dte.GHS
3. Secretary, M/o Home Affairs - with reference to D.O No.15011/89/2012-SC/ST-W

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PART I

GUIDELINES FOR MEDICO-LEGAL CARE FOR SURVIVORS/VICTIMS OF SEXUAL VIOLENCE

Glossary

Genetic sex and Anatomical Sex: Genetic sex refers to a person's sex chromosomes and anatomical sex refers to genitalia and gonads. It is assumed that appearance of genitalia corresponds to an individual's chromosomal pattern, eg. the Karyotype 46XX goes with the presence of ovaries, uterus and vagina, etc. However, this is not the case with intersexuality, wherein an individual's anatomical presentation is at variance with chromosomal pattern.

Gender identity: An individual's preferred gender role and presentation, as masculine, feminine, both or neither. Gender identity therefore is not determined by chromosomal or anatomical sex of a person.

Sexual orientation: An individual's sexual preference, whether homosexual, heterosexual or bisexual.

Gay/Homosexual: A man who is attracted towards other men.

Lesbian: A woman who is attracted to other women.

Bisexual: A person is attracted to both men and women.

Intersex: Non-conformity of an individual's body to prevalent ideas of maleness and femaleness. It is used as a blanket term for different biological possibilities and variations which may include, for instance, a large clitoris, absence of vagina, congenital absence of gonads among others.

Transgender: Individuals whose lived gender identity does not conform to their physiological appearance. It includes cultural categories such as hijras, transvestites as well as transitioning or post-operative transpersons. Transgender people may identify with either male or female gender identity, both, or neither.

Sex work: Is broadly defined as the exchange of money or goods in lieu of sexual services, either regularly or occasionally, involving female, male, and transgender adults.

Survivor: The Guidelines and proforma use the term survivor. The term survivor recognizes that the person has agency and she is capable of taking decisions despite being victimised, humiliated and traumatised due to the assault. Use of the term survivor by all those providing services recognizes these efforts and encourages them to believe the person and not pity her, whereas the term “victim” is understood as a person who doesn't possess agency and is not fully capable of comprehending situation at hand because of the victimhood faced. Given the judgmental attitudes towards the issue of rape and sexual assault, often police, health systems and other stake holders make decisions on behalf of the person because there is a belief that the person is so victimised that she may not be in a frame of mind to make decisions independently.

Victims: The term “ victim” literally means a person suffering harm including those who are subjected to non-consensual sexual act which could be sexual assault, rape or sexual violence. It also means a person is in need of compassion, care, validation, and support.

INTRODUCTION

Sexual violence is a significant cause of physical and psychological harm and suffering for women and children. Although sexual violence mostly affects women and girls, boys are also subject to child sexual abuse. Adult men, especially in police custody or prisons may also be subject to sexual violence, as also sexual minorities, especially the transgender community. Sexual violence takes various forms and the perpetrators range from strangers to state agencies to intimate partners; evidence shows that perpetrators are usually persons known to the survivor.

The World Health Organisation (WHO) defines Sexual Violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments/ advances and acts to traffic, or otherwise directed against a person's sexuality, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim in any setting, including but not limited to home and work." (WHO, 2003) Sexual assault, a form of sexual violence, is a term often used synonymously with rape. However, sexual assault could include anything from touching another person's body in a sexual way without the person's consent to forced sexual intercourse --- oral and anal sexual acts, child molestation, fondling and attempted rape. Forms of Sexual Violence include:

- Coerced/forced sex in marriage or live in relationships or dating relationships.
- Rape by strangers.
- Systematic rape during armed conflict, sexual slavery.
- Unwanted sexual advances or sexual harassment.
- Sexual abuse of children.
- Sexual abuse of people with mental and physical disabilities.
- Forced prostitution and trafficking for the purpose of sexual exploitation.
- Child and forced marriage.
- Denial of the right to use contraception or to adopt other measures to protect against STIs.
- Forced abortion and forced sterilization.
- Female genital cutting.
- Inspections for virginity.
- Forced exposure to pornography.
- Forcibly disrobing and parading naked any person.

(Please refer to **Annexure 1** for legal definitions.)

The Criminal Law Amendment Act (CLA) 2013 has expanded the definition of rape to include all forms of sexual violence-penetrative (oral, anal, vaginal) including by objects/weapons/fingers and non-penetrative (touching, fondling, stalking, etc.) and recognised right to treatment for all survivors/victims /victims of sexual violence by the public and private health care facilities. Failure to treat is now an offence under the law. The law further disallows any reference to past sexual practices of the survivor.

The health concerns of survivors/victims of sexual violence, and their right to health is an issue of importance. The Right to Health is not a fundamental right in India. However, the Supreme Court has interpreted the Right to Life as including the Right to Health. The Right to Health is enshrined in a number of international instruments ratified by India, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of Discrimination against Women (CEDAW), the Convention of the Rights of the Child (CRC), and the Convention on the Rights of Persons with Disabilities (CRPD).

The right to health care requires the state to ensure that appropriate physical and mental health services are available without discrimination and are accessible, acceptable and of good quality. This includes medical treatment for physical injuries, prophylaxis and testing for sexually transmitted infections, emergency contraception, and psychosocial support. Recognizing the right of all persons to health, health care workers must obtain informed consent of the survivors/victims of sexual violence prior to conducting medical examinations or initiating medico-legal investigations. All medico-legal examinations and procedures must respect the privacy and dignity of the survivor. To realize the right to health care of survivors/victims , health professionals must be trained to respond appropriately to their needs, in a sensitive and non-discriminatory manner respectful of the privacy, dignity and autonomy of each survivor. Health workers cannot refuse treatment or discriminate on the basis of gender, sexual orientation, disability, caste, religion, tribe, language, marital status, occupation, political belief, or other status. Refusal of medical care to survivors/victims of sexual violence and acid attack amounts to an offence under Section 166B of the Indian Penal Code read with Section 357C of the Code of Criminal Procedure.

The Ministry of Health and Family Welfare recognizes the critical role to be played by the Health professionals and health systems in caring for survivors/victims of sexual violence and collecting relevant evidence so that the culprit could be brought to the book.

While preparing the protocol and guidelines, the Committee under the Secretary (HFW) deliberated on the issues several times and took cognizance of the lack of uniform protocols and gaps in existing provision of medico legal care to survivors/victims of sexual violence, recommendations of the JVC, the CLA 2013 and Protection of Children from Sexual Offences (POCSO) 2012. While doing so, international standards especially the WHO Guidelines on medico legal care (2003) and Clinical and Policy Guidelines for responding to

Intimate Partner Violence (IPV) and sexual assault (2013) were referred to. The committee has drawn from the available evidence from health sector interventions, legal and other expert opinions and voices of survivors/victims.

The protocol and guidelines recognize the role of health sector in strengthening legal frameworks, developing comprehensive and multi-sectoral national strategies for preventing and eliminating all forms of sexual violence. Through these, the Ministry of Health and Family Welfare proposes to provide clear directives to all health facilities to ensure that all survivors of all forms of sexual violence, rape and incest, including people that face marginalisation based on disability, sexual orientation, caste, religion, class, have immediate access to health care services that includes immediate and follow up treatment, post rape care including emergency contraception, post exposure prophylaxis for HIV prevention and access to safe abortion services, police protection, emergency shelter, documentation of cases, forensic services and referrals for legal aid and other services. It recognizes the need to create an enabling environment for survivors/victims where they can speak out about abuse without fear of being blamed, where they can receive empathetic support in their struggle for justice and rebuild their lives after the assault.

The Ministry of Health and Family Welfare feels that sensitive handling can reduce self-blame and enhance healing for survivors. It also recognises the critical role of health professionals in their interface with the police, CWCs and judiciary. Such inter-sectoral collaboration is essential to provide services and deliver justice. The health system is committed to setting up services for survivors.

The Ministry places importance to:

- Provide medical assistance to the person suffering from violence
- Provide psychological assistance to both victim and perpetrator of Violence, if required. Health facilities can be instructed to handle all cases of Violence/suspected Gender Based Violence compassionately and to encourage them to seek the help of psychologist/psychiatrist.
- Help the law enforcing agencies to bring to book the perpetrators of Violence by conducting the necessary medico-legal examination.
- Refer those women, who come to healthcare facilities for self or childcare, to appropriate agencies as stated above, if it is suspected that they may be suffering from any kind of violence.
- Give parenting lessons to women coming to health care facilities for child care.
- Provide information about the ill-effects of drug abuse and alcoholism in order to help people in abstaining from such activities.
- Lay down standard operating procedures for the care, treatment and rehabilitation of survivors/victims of sexual violence.
- Propose to use these guidelines and protocol in all the health care facilities under the Ministry of Health and Family Welfare.

- Request State Government to follow them in their States/UTs.
- Although, this is essentially being done in all the health facilities, a uniform protocol and designated facilities would lead to prompt medical care. Apart from the present actions the Health care providers need to be more sensitive towards the victims of sexual violence. Additionally, the routine demographic data, detailed history can be recorded bringing out the root cause of the Violence. Accordingly the person can be referred to the appropriate agencies like Police, NGOs, Self-help Groups, Counsellors, etc. for appropriate redressal or dedicated centres providing all the required services under one roof.

These guidelines for health workers are aimed at providing an appropriate understanding of sexual violence and the needs and rights of survivors/victims of sexual violence, and to highlight the medical and forensic responsibilities of health professionals. It is also an important milestone in strengthening health system's response in addressing GBV. We are hopeful that concerted efforts will be taken to effectively implement these guidelines at the grass-root level.

The protocol and guidelines aim to achieve the following:

- Operationalise informed consent and respect autonomy of survivors in making decisions about examination, treatment and police intimation.
- Specific guidance on dealing with persons from marginalised groups such persons with disabilities, sex workers, LGBT persons, children, persons facing caste, class or religion based discrimination.
- Ensure gender sensitivity in the entire procedure by disallowing any mention of past sexual practices through comments on size of vaginal introitus, elasticity of vagina or anus. Further, it bars comments of built/height-weight/nutrition or gait that perpetuate stereotypes about 'victims'.
- Focus on history by recognising various forms and dynamics of sexual violence including activities that lead to loss of evidence
- Evidence collection based on science and history, with specific guidance for taking relevant samples and preservation of evidence.
- Lay down Standard Treatment protocols for managing health consequences of sexual violence.
- Lay down Guidelines for provision of first line psychological support.

HEALTH CONSEQUENCES AND ROLE OF HEALTH PROFESSIONALS

Health consequences of sexual violence

Sexual violence, in addition to being a violation of human rights, is an important public health issue as it has several direct and indirect health consequences. Survivors of sexual violence may present to health care services with varying signs and symptoms. For those survivors who do not reveal a history of sexual violence, the following signs and symptoms should prompt one to suspect the possibility of sexual abuse/assault:

Physical health consequences:

- Severe abdominal pain.
- Burning micturition.
- Sexual dysfunction.
- Dyspareunia.
- Menstrual disorders.
- Urinary tract infections.
- Unwanted pregnancy.
- Miscarriage of an existing fetus.
- Exposure to sexually transmitted infections (including HIV/AIDS).
- Pelvic inflammatory disease.
- Infertility.
- Unsafe abortion.
- Mutilated genitalia.
- Self-mutilation as a result of psychological trauma.

Psychological health consequences:

Short term psychological effects:
- Fear and shock.
- Physical and emotional pain.

- Intense self-disgust, powerlessness.
- Worthlessness.
- Apathy.
- Denial.
- Numbing.
- Withdrawal.
- An inability to function normally in their daily lives.

Long term psychological effects:

- Depression and chronic anxiety.
- Feelings of vulnerability.
- Loss of control/loss of self-esteem.
- Emotional distress.
- Impaired sense of self.
- Nightmares.
- Self-blame.
- Mistrust.
- Avoidance and post-traumatic stress disorder.
- Chronic mental disorders.
- Committing suicide or endangering their lives.

Role of the health facility and components of comprehensive health care response

Health professionals play a dual role in responding to the survivors of sexual assault. The first is to provide the required medical treatment and psychological support. The second is to assist survivors in their medico-legal proceedings by collecting evidence and ensuring a good quality documentation. After making an assessment regarding the severity of sexual violence, the first responsibility of the doctor is to provide medical treatment and attend to the survivor's needs. While doing so it is pertinent to remember that the sites of treatment would also be examined for evidence collection later.

Section 164 (A) of the Criminal Procedure Code lays out following legal obligations of the health worker in cases of sexual violence:

- Examination of a case of rape shall be conducted by a registered medical practitioner (RMP) employed in a hospital run by the government or a local authority and in the absence of such a practitioner, by any other RMP.
- Examination to be conducted without delay and a reasoned report to be prepared by the RMP.

- Record consent obtained specifically for this examination.
- Exact time of start and close of examination to be recorded.
- RMP to forward report without delay to Investigating Officer (IO), and in turn IO to Magistrate.

The Criminal Law Amendment Act 2013, in Section 357C Cr.PC says that both private and public health professionals are obligated to provide treatment. Denial of treatment of rape survivors is punishable under Section 166 B IPC with imprisonment for a term which may extend to one year or with fine or with both. Health professionals need to respond comprehensively to the needs of survivors. The components of a comprehensive response include:

- Providing necessary medical support to the survivor of sexual violence.
- Establishing a uniform method of examination and evidence collection by following the protocols. [in the Sexual Assault Forensic Evidence (SAFE) kit] [The contents of the kit are listed under Operational Issues (Page No.20)]
- Informed consent for examination, evidence collection and informing the police.
- First contact psychological support and validation.
- Maintaining a clear and fool-proof chain of custody of medical evidence collected.
- Referring to appropriate agencies for further assistance (eg. Legal support services, shelter services, etc).

It is important to establish a rapport with the survivor. The following guidelines are to help establish rapport:

- Never say or do anything to suggest disbelief regarding the incident.
- Do not pass judgmental remarks or comments that might appear unsympathetic.
- Appreciate the survivor's strength in coming to the hospital as it can serve to build a bond of trust.
- Convey important messages such as: the survivor is not responsible for precipitating the act of rape by any of her actions or inactions.
- Explain to the survivor that this is a crime/violence and not an act of lust or for sexual pleasure.
- Emphasize that this is not a loss of honour, modesty or chastity but a violation of his/her rights and it is the perpetrator who should be ashamed.
- Take help of a counselor, if required.

Facilitating procedures:

- The health worker should explain to the survivor in simple and understandable language the rationale for various procedures and details of how they will be performed.
- Specific steps when dealing with a survivor from marginalized groups such as children, persons with disability, LGBTI persons, sex workers or persons from minority

community, may be required as recommended in Chapter 3.

- Ensure confidentiality and explain to the survivor that she/he must reveal the entire history to health professional without fear. The survivor may be persuaded not to hide anything
- The fact that genital examination may be uncomfortable but is necessary for legal purposes should be explained to the survivor. The survivor should be informed about the need to carry out additional procedures such as x-rays, etc which may require him/her to visit to others departments.

While performing the examination, the purpose of forensic medical examination is to form an opinion on the following:

- Whether a sexual act has been attempted or completed. Sexual acts include genital, anal or oral penetration by the penis, fingers or other objects as well as any form of non-consensual sexual touching. A sexual act may not only be penetration by the penis but also slightest penetration of the vulva by the penis, such as minimal passage of the glans between the labia with or without emission of semen or rupture of the hymen.
- Whether such a sexual act is recent, and whether any harm has been caused to the survivor's body. This could include injuries inflicted on the survivor by the accused and by the survivor on the accused. However, the absence of signs of struggle does not imply consent.
- The age of the survivor needs to be verified in the case of adolescent girls/boys. Whether alcohol or drugs have been administered to the survivor needs to be ascertained.

GUIDELINES FOR RESPONDING TO SPECIAL GROUPS

This section aims to alert health professionals to the specific health care needs of different marginalized groups and equip them to respond to them in an appropriate, comprehensive and sensitive manner in a difficult situation. These guidelines stem from recognition of the historical stigmatization faced by marginalized groups in accessing health services.

For the purpose of these guidelines, marginalized groups are defined as

1. Individuals who face discrimination because their gender identity is not based on physiological appearance or where an individual's body doesn't fall in the rigid binary of male and female genitalia.
2. Individuals who face discrimination based on the sexual orientation they practice.
3. Individuals who face discrimination because they are involved in sex work.
4. Individuals with physical, psycho social and/or intellectual disability.
5. Individuals from religious minorities, castes or tribes.

Guiding principles for health professionals while working with special groups

1. Complete medical treatment and health care must be offered right at the outset at all health facilities. Health professionals should ensure that they are not biased against people belonging to marginalised groups and must treat them with respect
2. Health professionals must steer clear from demonstrating shock, disbelief, ridicule and ensure that such a conduct does not seep into the doctor- patient relationship.
3. Health professionals must acknowledge challenges and obstacles faced by marginalised groups in accessing health services and create an enabling atmosphere for them in the health facility.
4. Health professionals must enable survivors to feel at ease to be able to reveal the abuse that they have faced.
5. There must be cultural sensitivity while carrying out medical procedures. Cultural sensitivity refers to recognition of the caste, class, community, religion-determined behaviour and perceptions of the patient, without any bias/prejudice.

6. Individuals belonging to marginalised communities are often mistreated and ridiculed. In many instances, complaints from marginalised communities do not even get recorded. Therefore efforts must be made by health professionals to dialogue with the allied agencies such as the police, to record the complaint at the health facility if survivors express such a desire. Doing so at health institutions would be useful for survivors from marginalised groups as health institutions are perceived as less intimidating compared to police stations.
7. Health professionals must ensure that information on referral institutions providing good quality services for marginalised groups is available at the health facility.

A. Transgender and intersex persons

Medical practitioners must recognize that transgender and intersex people (TG/IS) are vulnerable to sexual violence due to the marginalization and discrimination they face. Under such circumstances, it is all the more essential that sexual violence faced by TG/IS people is recognized as such by health professionals who often serve as the first point of approach for a survivor of sexual violence. It is not uncommon for TG and IS persons to experience ridicule in the health facilities. Health professionals often ignorant of the variations in biology and gender identity and also tend to 'pathologize' them.

Guidelines for examination:

- Gender identity is not constituted by anatomy, especially appearance of genitals. Primacy should be given in the record to the survivor's stated gender identity and appropriate names and pronouns used.
- Intake forms and other documents that ask about gender or sex should have options as male/female/others.
- Genital anatomical variations of transgender and intersex people must be included in the examination proforma.
- Transgender and intersex people may be unwilling to report the case to law enforcement for fear of being exposed to inappropriate questions and abuse, therefore adequate care should be provided for those who do approach health institutions.
- Information on the intersex variations or transgender status of the survivor must be treated as confidential and not to be revealed without the survivor's consent.
- The inadvertent discovery during examination or history taking that a person is transgender or intersex must not be treated with ridicule, hostility, surprise, shock, or dismay. Such reactions convey that the person is being judged and is likely to make them uncomfortable in the health care setting.
- It is important to be aware of the possible health consequences that the sexual violence may have resulted in. For instance, transgender male individuals who still have ovaries and a uterus can become pregnant even when they were using testosterone and/or had

not been menstruating. Similarly, intersex variations which include non-typical genital appearance may still put some intersex women at risk of pregnancy. Health professionals must be aware of these variations and must anticipate health consequences accordingly.

- Some transgender or intersex survivors may want to talk about their perceptions of the role their gender identity might have played in making them vulnerable to an assault. Though Indian laws do not recognize gender identity-based hate crimes, it is important for the health professionals to record the survivor's account of the assault as part of the procedural history-taking, making note of the survivor's perception of the reasons for the assault, if so stated.
- Information about referral agencies that provide services to transgender or intersex survivors of sexual violence must be provided where available.

B. Persons of alternate sexual orientation

Sexual orientation refers to a person's sense of identity based on sexual attractions, related behaviour, and membership in a community of others who share those attractions. The 'normative' sexual orientation in our society is 'heterosexual', meaning that persons are expected to be attracted to others of the opposite sex. However, people may have various other sexual orientations. A person identifying with a homosexual identity for instance, is sexually attracted to a person of the same sex. There is widespread belief that homosexuality is a 'disease'; generally a 'mental illness' that needs to be cured or that homosexuality is a 'sin'. These ideas have no basis in fact and are responsible for deep-seated prejudices in society against lesbian, gay and bisexual people which often lead to a number of violent acts against them, including sexual violence.

Guidelines for examination

Even though the examination of a lesbian, gay or bisexual individual is not physically any different from that of a heterosexual person, a doctor should be especially sensitive to the former group's anxieties and concerns when it comes to such examinations.

- There should be no judgment on the person's sexual orientation in general or as a cause of the assault.
- Confidentiality of their sexual orientation should be maintained. One should not discuss or mention it to the other staff members unless needed for treatment reasons.
- The health professional should not express shock, wonder, or any other negative emotions when a person reveals their sexual orientation. The speech and behaviour of the health professional should remain inclusive.
- Old injuries or fact that a person is 'habituated to anal sex' should NOT be recorded.
- Treatment should NOT be denied to any person based on/due to their sexual orientation.

- The doctor and hospital staff should be understanding towards the survivor and should provide care and treatment with sensitivity.
- The doctor or the hospital staff should not give any advice or 'offer solutions' to 'cure' them of their sexual orientation.
- Lesbian, gay, bisexual and transgender persons are likely to be targets of hate crimes and may want to talk about the role their sexual orientation played in making them vulnerable to sexual violence. Their experience should be given a sincere hearing and validated. The survivors should be assured that it was not their fault that they were sexually assaulted.

C. Sex workers:

While women remain the largest group involved in sex work, the numbers of men acknowledged to be involved is growing. Although far less numerous, transgender individuals - both transvestites and trans-sexuals - are also active in sex work. It is important to bear in mind that just because sex workers exchange sexual acts for money or goods, does not mean that they cannot be sexually assaulted. The Supreme Court of India has acknowledged that a woman who is a sex worker has the right to decide with whom she will have sex, and so any non-consensual intercourse with her would therefore amount to rape. Sexual abuse by clients, police, pimps, brothel owners and others is commonly encountered by sex workers. Coercion to perform sexual acts by use of verbal threats, physical force and forced unwanted sexual acts by clients have been reported by sex workers as some of the types of sexual violence that they face.

Guidelines for examination

While examining sex workers reporting sexual violence, it is important to keep in mind that sex workers face a number of challenges due to the nature of their work when they approach the healthcare system. They have already faced a significant amount of discrimination from various agencies of society at every stage and hence their decision to approach a health care facility for treatment or examination should be considered a courageous one.

- A sex worker has a right to receive treatment and not providing it for any reason is punishable by law.
- Do not make assumptions about the person's health. Myths such as, “Sex workers are all addicts/HIV positive” are only myths. These propagate an unhealthy assumption of this group which may lead to further marginalization.
- Sex workers can be of any gender. No statements blaming the survivor or his/her profession for the violence faced should be made.
- Only information of the current episode of violence that the survivor is reporting must be documented. Any information of past sexual encounters is irrelevant to the current incident of sexual violence and should not be noted.

D. Persons with Disability

Persons with disability includes those who have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. Women and children with disability are particularly vulnerable to violence, discrimination, stigma and neglect. In fact, persons with disabilities may be repeatedly victimized, especially by caretakers. Some reports suggest that women and girls with disabilities are three times more likely to be victims of physical and sexual abuse as compared to other women and girls. Women and girls with disabilities who are institutionalized are at risk of abuse in shelters and hospitals. This has now been recognized as 'custodial rape' in the revised Indian Penal Code (Criminal Law Amendment Act, 2013). Women with disabilities are often unable to report sexual abuse because of the obvious barriers to communication, as well as their dependency on carers who may also be abusers. When they do report, their complaints are not taken seriously and the challenges they face in expressing themselves in a system that does not create an enabling environment to allow for such expression, complicates matters further. India has ratified the United Nations Convention on Rights of Persons with Disabilities (UNCRPD) which mandates that country must make specific provisions to end discrimination and violence faced by persons with disabilities. It also mandates that healthcare systems must make necessary provisions to ensure access to health care to persons with disabilities. However, our health systems in general are not friendly to persons with disabilities.

Guidelines for examination:

- Be aware of the nature and extent of disability that the person has and make necessary accommodations in the space where the examination is carried out.
- Do not make assumptions about the survivor's disability and ask about it before providing any assistance.
- Do not assume that a person with disability cannot give history of sexual violence himself/herself. Because abuse by near and dear ones is common, it is important to not let the history be dictated by the caretaker or person accompanying the survivor. History must be sought independently, directly from the survivor herself/himself. Let the person decide who can be present in the room while history is being sought and examination conducted.
- Make arrangements for interpreters or special educators in case the person has a speech/hearing or cognitive disability. Maintain a resource list with names, addresses and other contact details of interpreters, translators and special educators in and around your hospital, who could be contacted for assistance.
- Even while using the services of an interpreter, communicate with the person directly as much as possible, and be present while the interpreter or special educator is with the person.

- Understand that an examination in the case of a disabled person may take longer. Do not rush through things as it may distress the survivor. Take time to make the survivor comfortable and establish trust, in order to conduct a thorough examination.
- Recognize that the person may not have been through an internal examination before. The procedure should be explained in a language they can understand. They may have limited knowledge of reproductive health issues and not be able to describe what happened to them. They may not know how they feel about the incident or even identify that a crime was committed against them.
- Ensure that adequate and appropriate counselling services are provided to the survivors. If required, the services of an expert may be required in this regard, which should be made available.
- Consent: All persons are ordinarily able to give or refuse to give informed consent, including persons with mental illness and intellectual disabilities, and their informed consent should be sought and obtained before any medical examination. Some specific steps may be required when taking informed consent from persons with mental illness or those with intellectual disabilities. If it is deemed necessary, such persons should (a) be provided the necessary information (what the procedure involves, the reason for doing the procedure, the potential risks and discomforts) in a simple language and in a form that makes it easy for them to understand the information; (b) be given adequate time to arrive at a decision; (c) be provided the assistance of a friend/colleague/care-giver in making the informed consent decision and in conveying their decision to medical personnel. The decision of the person to either give consent or refuse consent with the above supports, to the medical examination, should be respected.

E. People facing caste, class or religion based discrimination

Sexual violence is mostly perpetrated by those in a position of power upon those who are relatively vulnerable. This position of power may be a function of a person's gender, class, caste, religion, ethnicity, sexual orientation and/or other factors. In India, the caste or religion that a person belongs to impacts on the power and influence that they exercise. Women are seen as symbols of honour of their social community. Violating the bodily integrity of women is equated with violating the honour of the entire community and bringing disgrace to it. Health professionals should be aware that while women and girls are specifically targeted during communal or caste conflicts, other members of the targeted community (including young boys) may also be subjected to sexual violence.

Guidelines for examination:

- Do not pass any explicit or implicit comments, or in any other way communicate your personal opinion, about the person's caste or religion while medically treating them.
- Do not ask the person who is being given medical treatment any questions about her religion/caste, except those that are relevant to the nature of violence she has faced or the kind of treatment she requires.

- Do not make assumptions about the person's life, the number of children she has, the kind of treatment that she may be willing to undergo etc.
- In a situation of communal/caste conflict, health professionals should sensitively enquire about and look for signs and symptoms that suggest sexual violence, among all women and girls who access the health system, even where they do not explicitly claim to have suffered sexual violence.
- Some survivors may be willing to talk about the role that their religious or caste identity has played in the commission of the offence. The survivors experience should be listened to and recorded in the Medical Report.
- These are often reports that actions of the Police and other State/administrative functionaries are partisan during communal/caste and other kinds of conflict. This must be kept in mind while providing medical treatment to women in conflict situations, and the actions/instructions of the police/state functionaries should not interfere with the provision of medical treatment to the survivor and the documentation.

GUIDELINES FOR RESPONDING TO CHILDREN

The prevalence of child sexual abuse in India is known to be high. A National Study on Child Abuse conducted by the Ministry of Women and Child Development showed that more than 53 per cent children across 13 states reported facing some form of sexual abuse while 22 per cent faced severe sexual abuse. Both boys and girls reported facing sexual abuse.

Most commonly, abusers are persons who are well known to the child and may even be living in the household. Children are considered soft targets for sexual abuse because they may not realize that they are being abused. Abusers are also known to use chocolates and toys to lure children. Further, children are more easily threatened and less likely to speak out about the abuse.

While the principles of medical examination and treatment for children remains the same as that for adults, it is important to keep some specific guidelines in mind:

- In case the child is under 12 years of age, consent for examination needs to be sought from the parent or guardian.
- Children may be accompanied by the abuser when they come for medical treatment, so be aware and screen when you suspect abuse. In such situations, a female person appointed by the head of the hospital/institution may be called in to be present during the examination.
- Do not assume that because the child is young he/she will not be able to provide a history. History seeking can be facilitated by use of dolls and body charts.
- Believe what is being reported by the child. There are misconceptions that children lie or that they are tutored by parents to make false complaints against others. Do not let such myths affect the manner in which you respond to cases of child sexual abuse.
- Specific needs of children must be kept in mind while providing care to child survivors. Doses of treatment will have to be adjusted as required in terms of medical treatment. For psychological support, it is imperative to speak with the carer/s of the survivor in addition the survivor themselves.
- Health professionals must make a note of the following aspects while screening for sexual abuse. Assurance of confidentiality and provision of privacy are keys to enabling children to speak about the abuse. However genital and anal examination should not be

conducted mechanically or routinely. A few indicators for routine enquiry are –

- Pain on urination and /or defecation
- Abdominal pain/ generalized body ache
- Inability to sleep
- Sudden withdrawal from peers/ adults
- Feelings of anxiety, nervousness, helplessness
- Inability to sleep
- Weight loss
- Feelings of ending one's life

OPERATIONAL ISSUES

Every hospital must have a Standard Operating Procedure (SOP) for management of cases of sexual violence:

1. To provide comprehensive services.
2. For the smooth handling of the cases and clarity of roles of each staff.
3. To have uniform practice across all doctors in the hospital.

The SOP must be printed and available to all staff of the hospital.

- Any registered medical practitioner can conduct the examination and it is not mandatory for a gynaecologist to examine such a case. In case of a girl or woman, every possible effort should be made to find a female doctor but absence of availability of lady doctor should not deny or delay the treatment and examination. In case a female doctor is not available for the examination of a female survivor, a male doctor should conduct the examination in the presence of a female attendant. In case of a minor/person with disability, his/her parent/guardian/any other person with whom the survivor is comfortable may be present.
- In the case of a transgender/intersex person, the survivor should be given a choice as to whether she/he wants to be examined by a female doctor, or a male doctor. In case a female doctor is not available, a male doctor may conduct the examination in the presence of a female attendant.
- Police personnel must not be allowed in the examination room during the consultation with the survivor. If the survivor requests, her relative may be present while the examination is done.
- There must be no delay in conducting an examination and collecting evidence.
- Providing treatment and necessary medical investigations is the prime responsibility of the examining doctor. Admission, evidence collection or filing a police complaint is not mandatory for providing treatment.
- The history taking & examination should be carried out in complete privacy in the special room set up in the hospital for examination of sexual violence survivor. The room should have adequate space, sufficient lighting, a comfortable examination table, all the equipment required for a thorough examination, and the sexual assault forensic

evidence (SAFE) kit containing the following items for collecting and preserving physical evidence following a sexual violence:

- Forms for documentation
- Large sheet of paper to undress over
- Paper bags for clothing collection
- Catchment Paper
- Sterile cotton swabs and swab guards for biological evidence collection
- Comb
- Nail Cutter
- Wooden stick for finger nail scrapings
- Small scissors
- Urine sample container
- Tubes/ vials/ vaccutainers for blood samples [Ethylenediaminetetraacetic acid (EDTA), Plain, Sodium fluoride]
- Syringes and needle for drawing blood
- Distilled water
- Disposable gloves
- Glass slides
- Envelopes or boxes for individual evidence samples
- Labels
- Lac(sealing wax) Stick for sealing
- Clean clothing, shower/hygiene items for survivors use after the examination

Other items for a forensic/medical examination and treatment that may be included are:

- Woods lamp/Good torch
- Vaginal speculums
- Drying rack for wet swabs &/or clothing
- Patient gown, cover sheet, blanket, pillow
- Post-It notes to collect trace evidence
- Camera (35mm, digital with colour printer)
- Microscope
- Colposcope/ Magnifying glass
- Toluidine blue dye
- 1% Acetic acid diluted spray
- Urine Pregnancy test kit
- Surgilube
- Medications

- The collected samples for evidence may be preserved in the hospital till such time that police are able to complete their paper work for dispatch to forensic lab test including DNA.
- After the examination is complete the survivor should be permitted to wash up, using the toiletries and the clothing provided by the hospital if her own clothing is taken as evidence.
- Admission should not be insisted upon unless the survivor requires indoor stay for observation/treatment.
- Survivors of sexual violence should receive all services completely free of cost. This includes OPD/inpatient registration, lab and radiology investigations, Urine Pregnancy Test (UPT) and medicines. The casualty medical officer must label the case papers for any sexual violence case as “free” so that free treatment is ensured. Medicines should be prescribed from those available in the hospital. If certain investigations or medicines are not available, the social worker at the hospital should ensure that the survivor is compensated for investigations/ medicines from outside.
- A copy of all documentation (including that pertaining to medico-legal examination and treatment) must be provided to the survivor free of cost.

MEDICAL EXAMINATION AND REPORTING FOR SEXUAL VIOLENCE

The following guidelines are for health professionals when a survivor of sexual violence reports to a hospital. The guidelines describe in detail the stepwise approach to be used for a comprehensive response to the sexual violence survivor as follows:

I. Initial resuscitation/ first Aid
ii. Informed consent for examination, evidence collection, police procedures
iii. Detailed History taking
iv. Medical Examination
v. Age Estimation (physical/dental/radiological) – if requested by the investigating agency.
vi. Evidence Collection as per the protocol
vii. Documentation
viii. Packing, sealing and handing over the collected evidence to police
ix. Treatment of Injuries
x. Testing/prophylaxis for STIs, HIV, Hepatitis B and Pregnancy
xi. Psychological support & counseling
xii. Referral for further help (shelter, legal support)

Record the name of hospital where the survivor is being examined followed by the following:

2-5. Name, address, age and sex (male/female/other) of the survivor

6-7. Date and time of receiving the patient in the hospital and commencement of examination

8. Name of the person who brought the survivor and relationship to accompanying persons.

12. Informed consent: A survivor may approach a health facility under three circumstances:

a) on his/her own only for treatment for effects of assault;
b) with a police requisition after police complaint; or
c) with a court directive.

- If a person has come directly to the hospital without the police requisition, the hospital is bound to provide treatment and conduct a medical examination with consent of the survivor/parent/guardian (depending on age). A police requisition is not required for this.
- If a person has come on his/her own without FIR, s/he may or may not want to lodge a Complaint but requires a medical examination and treatment. Even in such cases the doctor is bound to inform the police as per law. However neither court nor police can force the survivor to undergo medical examination. It has to be with the informed consent of the survivor/ parent/ guardian (depending on the age). In case the survivor does not want to pursue a police case, a MLC must be made and she must be informed that she has the right to refuse to file FIR. An informed refusal must be documented in such cases.
- If the person has come with a police requisition or wishes to lodge a complaint later, the information about medico-legal case **(MLC) no. & police station** should be recorded.
- Doctors are legally bound to examine and provide treatment to survivors of sexual violence. The timely reporting, documentation and collection of forensic evidence may assist the investigation of this crime. Police personnel should not be present during any part of the examination.

In all three circumstances, it is mandatory to seek an **Informed Consent/refusal** for examination and evidence collection. Consent should be taken for the following purposes: examination, sample collection for clinical and forensic examination, treatment and police intimation.

Doctors shall inform the person being examined about the nature and purpose of examination and in case of child to the child's parent/guardian/ or a person in whom the child reposes trust. This information should include:

a) The medico-legal examination is to assist the investigation, arrest and prosecution of those who committed the sexual offence. This may involve an examination of the mouth, breasts, vagina, anus and rectum as necessary depending on the particular circumstances.
b) To assist investigation, forensic evidence may be collected with the consent of the survivor. This may include removing and isolating clothing, scalp hair, foreign substances from the body, saliva, pubic hair, samples taken from the vagina, anus, rectum, mouth and collecting a blood sample.
c) The survivor or in case of child, the parent/guardian/or a person in whom the child reposes trust, has the right to refuse either a medico-legal examination or collection of evidence or both, but that refusal will not be used to deny treatment to survivor after sexual violence.
d) As per the law, the hospital/ examining doctor is required/duty bound to inform the police about the sexual offence. However, if the survivor does not wish to participate in the police investigation, it should not result in denial of treatment for sexual violence.

Emphasize that seeking treatment is critical for the survivor's well-being.

- The survivor or guardian may refuse to give consent for any part of examination. In this case the doctor should explain the importance of examination and evidence collection, however the refusal should be respected. It should also be explained that refusal for such examination will not affect/compromise treatment. Such informed refusal for examination and evidence collection must be documented.
- In case there is informed refusal for police intimation, then that should be documented. At the time of MLC intimation being sent to the police, a clear note stating “informed refusal for police intimation” should be made.
- Only in situations, where it is life threatening the doctor may initiate treatment without consent as per section 92 of IPC.
- The consent form must be signed by the person him/herself if s/he is above 12 yrs. of age. Consent must be taken from the guardian/ parent if the survivor is under the age of 12 years.
- In case of persons with mental disability, please refer to section on “Persons with Disabilities”
- The consent form must be signed by the survivor, a witness and the examining doctor.
- Any major 'disinterested', person may be considered a witness

13. Two marks of identification such as moles, scars, tattoos etc., preferably from the exposed parts of the body should be documented. While describing identification mark emphasis should be on size, site, surface, shape, colour, fixity to underlying structures. Left Thumb impression is to be taken in the space provided.

14. Relevant medical/surgical history

- Menstrual history (Cycle length and duration, Date of last menstrual period).If the survivor is menstruating at the time of examination then a second examination is required on a later date in order to record the injuries clearly. Some amount of evidence is lost because of menstruation. Hence it is important to record whether the survivor was menstruating at the time of assault/examination
- Vaccination history is important with regard to tetanus and hepatits B, so as to ascertain if prophylaxis is required.

15. Sexual violence history

- Be sensitive to the survivor as she has experienced a traumatic episode and s/he may not be able to provide all the details. Explain to him/her that the process of history taking is important for further treatment and for filing a case if needed.
- Create an environment of trust so that the survivor is able to speak out. Do not pass judgmental remarks.

- A relative could be present with the consent of the survivor, if s/he is comfortable.
- Details of the date, time and location of incident of sexual violence should be recorded.
- In case of more than one assailant, their number should be recorded along with the names and relation if known.
- One must note who is narrating the incident- survivor or an informant. If history is narrated by a person other than the survivor herself, his/her name should be noted. Especially if the identity of assailants is revealed it is better to also have a counter-signature of the informant.
- The doctor should record the complete history of the incident, in survivor's own words as it has evidentiary value in the court of law.
- Use of any Physical violence during assault must be recorded with detailed description of the type of violence and its location on the body (eg. Beating on the legs, biting cheeks, pulling hair, kicking the abdomen etc.).
- Note history of injury marks that the survivor may state to have left on the assailant's body as it can be matched eventually with the findings of the assailant's examination.
- If any weapon(s) were used such as sticks, acid burns, gun shots, knife attacks etc.; if the use of drugs/alcohol was involved. Verbal threats should be recorded in survivor's words, eg. harming her or her near and dear ones.
- Information regarding attempted or completed penetration by penis/ finger/ object in vagina/ anus/ mouth should be properly recorded. There could also be other acts such as masturbation of the assailant by the survivor, masturbation of the survivor by the assailant, oral sex by the assailant on the survivor or sucking, licking, kissing of body parts. Information about emission of semen, use of condom, sucking or spitting along with the location should be clearly stated. Information about emission of semen outside the orifices should be elicited as swabs taken from such sites can have evidentiary value. Information regarding use of condom during the assault is relevant because in such cases, vaginal swabs and smears would be negative for sperm/semen.
- While recording history of sexual violence, it is important to enquire and record in simple language whether these acts occurred or not. A clear differentiation should be made between a 'negative' and 'not sure' history. If the survivor does not know if a particular act occurred, it should be recorded as “did not know”'.
- One should not feel awkward in asking for history of the sexual act. If details are not entered it may weaken the survivor's testimony. The details of history are what will also guide the examination, treatment and evidence collection and therefore seeking a complete history is critical to the medical examination process, sample collection for clinical & forensic examination, treatment and police intimation.
- In case of children, illustrative books, body charts or a doll can be used if available, to elicit the history of the assault. When it is difficult to elicit history from a child, please call an expert.
- Details of clothing worn at the time of assault should be recorded.
- Post assault Information should be collected on activities like changed clothes, cleaned clothes, bathed/ urinated/ defecated/ showered/ washed genitals (in all cases) and rinsing mouth, drinking, eating (in oral sexual violence)/ had sexual intercourse after the incident of sexual violence. This would have a bearing on the trace evidence collected from these sites.

- If vaginal swabs for detection of semen are being taken then record history of last consensual sexual intercourse in the week preceding the examination. It should be recorded because detection of sperm/semen is a valuable evidence. While seeking such history, explain to the survivor why this information is being sought, because the survivor may not want to disclose such history as it may seem invasive.
- Information related to past abuse (physical/sexual/emotional) should be recorded in order to understand if there is any health consequence related to the assault. This information should be kept in mind during examination & interpretation of findings.
- Relevant Medical & Surgical History: Relevant medical history in relation to sexually transmitted infections (gonorrhea, HIV, HBV etc.) can be elicited by asking about discharge per-urethra/per-anus, warts, ulcers, burning micturition, lower abdominal pain etc. Based on this information reexamination/ investigations can be done after incubation period of that disease. If there is vaginal discharge, record its type, i.e., texture, colour, odour, etc.
- Relevant surgical history in relation to treatment of fissures/injuries/scars of ano-genital area should be noted.

16. General physical examination

- Record if the person is oriented in space and time and is able to respond to all the questions asked by the doctor. Any signs of intoxication by ingestion or injection of drug/alcohol must be noted.
- Pulse. B.P., respiration, temperature and state of pupils is recorded.
- A note is made of the state of clothing if it is the same as that worn at the time of assault. If it is freshly torn or has stains of blood/ semen/ mud etc.; the site, size, and colour of stains should be described.

17. Examination for injuries

- Presence of injuries is only observed in one third cases of forced sexual intercourse. Absence of injuries does not mean the survivor has consented to sexual activity. As per law, if resistance was not offered that does not mean the person has consented.
- The entire body surface should be inspected carefully for signs of bruises, physical torture injuries, nail abrasions, teeth bite marks, cuts, lacerations, fracture, tenderness, any other injury, boils, lesions, discharge specially on the scalp, face, neck, shoulders, breast, wrists, forearms, medial aspect of upper arms, thighs and buttocks
- Describe all the injuries. Describe the type of injury (abrasion, laceration, incised, contusion etc.), site, size, shape, colour, swelling, signs of healing, simple/grievous, dimensions. Mention possible weapon of infliction such as - hard, blunt, rough, sharp, etc. Refer to Annexure 2 for noting time of injury
- Injuries are best represented when marked on body charts. They must be numbered on the body charts and each must be described in detail.
- Describe any stains seen on the body - the type of stain (blood, semen, lubricant, etc.) its actual site, size and colour. Mention the number of swabs collected and their sites.

18. Local examination of genital parts/other orifices

A. External genital area and Perineum is observed carefully for evidence of injury, seminal stains and stray pubic hair. Pubic hair is examined for any seminal deposits/ stray hair. Combing is done to pick up any stray hair or foreign material, and sample of pubic hair, and matted pubic hair is taken and preserved. If pubic hair is shaven, a note is made.

B. In case of female survivors, the vulva is inspected systematically for any signs of recent injury such as bleeding, tears, bruises, abrasions, swelling, or discharge and infection involving urethral meatus & vestibule, labia majora and minora, fourchette, introitus and hymen.

- Examination of the vagina of an adult female is done with the help of a sterile speculum lubricated with warm saline/ sterile water. Gentle retraction allows for inspection of the vaginal canal. Look for bruises, redness, bleeding and tears, which may even extend onto the perineum, especially in the case of very young girls. In case injuries are not visible but suspected; look for micro injuries using good light and a magnifying glass/ colposcope whatever is available. If 1% Toluidine blue is available it is sprayed and excess is wiped out. Micro injuries will stand out in blue. Care should be taken that all these tests are done only after swabs for trace evidence are collected.
- Per speculum examination is not a must in the case of children/young girls when there is no history of penetration and no visible injuries. The examination and treatment as needed may have to be performed under general anaesthesia in case of minors and when injuries inflicted are severe. If there is vaginal discharge, note its texture, colour, odour.
- **Per-Vaginum examination commonly referred to by lay persons as 'two-finger test',** must not be conducted for establishing rape/sexual violence and the size of the vaginal introitus has no bearing on a case of sexual violence. Per vaginum examination can be done only in adult women when medically indicated.
- The status of hymen is irrelevant because the hymen can be torn due to several reasons such as cycling, riding or masturbation among other things. An intact hymen does not rule out sexual violence, and a torn hymen does not prove previous sexual intercourse. Hymen should therefore be treated like any other part of the genitals while documenting examination findings in cases of sexual violence. Only those that are relevant to the episode of assault (findings such as fresh tears, bleeding, edema etc.) are to be documented.
- Genital findings must also be marked on body charts and numbered accordingly.

C. Bleeding/swelling/tears/discharge/stains/warts around the anus and anal orifice must be documented. Per-rectal examination to detect tears/stains/fissures/hemorrhoids in the anal canal must be carried out and relevant swabs from these sites should be collected.

D. Oral cavity should also be examined for any evidence of bleeding, discharge, tear, odema, tenderness.

19. Collection of samples for hospital laboratory/ clinical laboratory

- If requested by police radiographs of wrist, elbow, shoulders, dental examination etc. can be advised for age estimation. Refer to **Annexure 3** for details on Age estimation.
- For any suspected fracture/injury- appropriate investigation for the relevant part of the body is advised.
- Urine Pregnancy test should be performed by the doctor on duty and the report should be entered.
- Blood is collected for evidence of baseline HIV status, VDRL and HbsAg.

20. Collection of samples for central/ State forensic science laboratory

- After assessment of the case, determine what evidence needs to be collected. It would depend upon nature of assault, time lapsed between assault and examination and if the person has bathed/washed herself since the assault. Please refer to Table in **Annexure 4** indicative of type of evidence to be collected in specific cases.
- If a woman reports within 96 hours (4 days) of the assault, all evidence including swabs must be collected, based on the nature of assault that has occured. The likelihood of finding evidence after 72 hours (3 days) is greatly reduced; however it is better to collect evidence up to 96 hours in case the survivor may be unsure of the number of hours lapsed since the assault.

- The spermatozoa can be identified only for 72 hours after assault. So if a survivor has suffered the assault more than three days ago, please refrain from taking swabs for spermatozoa. In such cases swabs should only be sent for tests for identifying semen.
- Evidence on the outside of the body and on materials such as clothing can be collected even after 96 hours.
- The nature of swabs taken is determined to a large extent by the history and nature of assault and time lapse between incident and examination. For example, if the survivor is certain that there is no anal intercourse; anal swabs need not be taken.
- Request the survivor to stand on a large sheet of paper, so as to collect any specimens of foreign material e.g. grass, mud, pubic or scalp hair etc. which may have been left on her person from the site of assault/ from the accused. This sheet of paper is folded carefully and preserved in a bag to be sent to the FSL for trace evidence detection.
- Clothes that the survivor was wearing at the time of the incident of sexual violence are of evidentiary value if there is any stains/tears/trace evidence on them. Hence they must be preserved. Please describe each piece of clothing separately with proper labeling. Presence of stains - semen, blood, foreign material etc - should be properly noted. Also note if there are any tears or other marks on the clothes. If clothes are already changed then the survivor must be asked for the clothes that were worn at the time of assault and these must be preserved.
- Always ensure that the clothes and samples are air dried before storing them in their respective packets. Ensure that clothing is folded in such a manner that the stained parts are not in contact with unstained parts of the clothing. Pack each piece of clothing in a separate bag, seal and label it duly.

Body evidence:

- Swabs are used to collect bloodstains on the body, foreign material on the body surfaces seminal stains on the skin surfaces and other stains. Detection of scalp hair and pubic hair of the accused on the survivor's body (and vice-versa) has evidentiary value. Collect loose scalp and pubic hair by combing. Intact scalp and pubic hair is also collected from the survivor so that it can be matched with loose hair collected from the accused. All hair must be collected in the catchment paper which is then folded and sealed.
- If there is struggle during the sexual violence, with accused and survivor scratching each other, then epithelial cells of one may be present under the nails of the other that can be used for DNA detection. Nail clippings and scrapings must be taken for both hands and packed separately. Ensure that there is no underlying tissue contamination while clipping nails.
- Blood is collected for grouping and also helps in comparing and matching blood stains at the scene of crime.
- Collect blood and urine for detection of drugs/alcohol as the influence of drugs/ alcohol has a bearing on the outcome of the entire investigation. If such substances are found in the blood, the validity of consent is called into question. In a given case, for instance, there may not be any physical or genital injuries. In such a situation, ascertaining the presence of drug/alcohol in the blood or urine is important since this may have affected the survivor's ability to offer resistance. Urine sample may be collected in a container to test for drugs and alcohol levels as required.
- Venous blood is collected with the sterile syringe and needle provided and transferred to 3 sterile vials/ vaccutainers for the following purposes: Plain Vial/Vaccutainer - Blood grouping and drug estimation, Sodium Fluoride - Alcohol estimation, EDTA - DNA Analysis.
- Collect oral swab for detection of semen and spermatozoa. Oral swabs should be taken from the posterior parts of the buccal cavity, behind the last molars where the chances of finding any evidence are highest.

Genital and anal evidence

- In the case of any suspected seminal deposits on the pubic hair of the woman, clip matted portion of the pubic hair; allow drying in the shade and placing in an envelope.
- Pubic hair of the survivor is then combed for specimens of the offender's pubic hair. A comb must be used for this purpose and a catchment paper must be used to collect and preserve the specimens. Cuttings of the pubic hair are also taken for the purpose of comparison or to serve as control samples. If pubic hair has been shaved, do not fail to make a mention of it in the records.
- Take two swabs from the vulva, vagina, anal opening for ano-genital evidence. Swabs must be collected depending on the history and examination. Swabs from orifices must be collected only if there is a history of penetration. Two vaginal smears are to be prepared on the glass slide provided, air-dried in the shade and sent for seminal fluid/ spermatozoa examination.

- Often lubricants are used in penetration with finger or object, so relevant swabs must be taken for detection of lubricant. Other pieces of evidence such as tampons (may be available as well), which should be preserved.
- Swab sticks for collecting samples should be moistened with distilled water provided.
- Swabs must be air dried, but not dried in direct sunlight. Drying of swabs is absolutely mandatory as there may be decomposition/degradation of evidence which can render it un-usable.
- Vaginal washing is collected using a syringe and a small rubber catheter. 2-3 ml of saline is instilled in the vagina and fluid is aspirated. Fluid filled syringe is sent to FSL laboratory after putting a knot over the rubber catheter.
- While handing over the samples, a requisition letter addressed to the FSL, stating what all samples are being sent and what each sample needs to be tested for should be stated. For example, "Vaginal swab to be tested for semen". This form must be signed by the examining doctor as well as the officer to whom the evidence is handed over.
- Please ensure that the numbering of individual packets is in consonance with the numbering on the requisition form. Specimens sent to the Forensic Science laboratory will not be received unless they are packed separately, sealed, labeled and handed over.

21. Provisional clinical opinion

- Drafting of provisional opinion should be done immediately after examination of the survivor on the basis of history and findings of detailed clinical examination of the survivor.
- The provisional opinion must, in brief, mention relevant aspects of the history of sexual violence, clinical findings and samples which are sent for analysis to FSL.
- An inference must be drawn in the opinion, correlating the history and clinical findings.

The following section offers some scenarios about ways to draft a provisional and final opinion. However, this list is not exhaustive and readers are advised to form provisional opinions based on the examples given below.

It should be always kept in mind that normal examination findings neither refute nor confirm the forceful sexual intercourse. Hence circumstantial/other evidence may please be taken into consideration.

Absence of injuries or negative laboratory results may be due to:

a. Inability of survivor to offer resistance to the assailant because of intoxication or threats
b. Delay in reporting for examination
c. Activities such as urinating, washing, bathing, changing clothes or douching which may lead to loss of evidence
d. Use of condom/vasectomy or diseases of vas

This reasoning must be mentioned while formulating the opinion.

Genital injuries	Physical injuries	Opinion	Rationale why forced penetrative sex cannot be ruled out	What can FSL detect
Present	Present	There are signs suggestive of recent use of force/forceful penetration of vagina/ anus. Sexual violence cannot be ruled out.	Evidence for semen and spermatozoa are yet to be tested by laboratory examinations in case of penile penetration.	Evidence of semen except when condom was used
Present	Absent	There are signs suggestive of recent forceful penetration of vagina/anus.	Evidence for semen and spermatozoa are yet to be tested in case of penile penetration. The lack of physical injuries could be because of the survivor being unconscious, under the effect of alcohol/drugs, overpowered or threatened. It could be because, there was fingering or penetration by object with or without use of lubricant - which is an offence under Sec 375 IPC	Evidence of semen or lubricant except when condom was used
Absent	Present	There are signs of use of force, however vaginal or anal or oral penetration cannot be ruled out.	The lack of injuries could be because of the survivor being unconscious, under the effect of alcohol /drugs, overpowered or threatened or use of lubricant.	Evidence of semen or lubricant
Absent	Absent	There are no signs of use of force; however final opinion is reserved pending availability of FSL reports. Sexual violence cannot be ruled out.	The lack of genital injuries could be because of use of lubricant. The lack of physical injuries could be because of the survivor being unconscious, under the effect of alcohol/drugs, overpowered or threatened. It could also be because, there was fingering or penetration by object with use of lubricant- which is an offence under Sec 375 IPC	Evidence of semen, lubricant and drug/alcohol

22. Treatment guidelines and psychosocial support

Sexually transmitted infections:

- If clinical signs are suggestive of STD, collect relevant swabs and start PEP. If there are no clinical signs, wait for lab results. For non-pregnant women, the preferred choice is Azithromycin 1gm stat or Doxycycline 100mg bd for 7days, with Metronidazole 400 mg for 7days with antacid.
- For pregnant women, Amoxycillin/Azithromycin with Metronidazole is preferred. Metronidazole should NOT to be given in the 1st trimester of pregnancy.

Hepatitis B. Draw a sample of blood for HBsAg and administer 0.06 ml/kg HB immune globulin immediately (anytime upto 72 hours after sexual act).

Pregnancy Prophylaxis (Emergency contraception)

- The preferred choice of treatment is 2 tablets of Levonorgestrel 750 ì g, within 72 hours. If vomiting occurs, repeat within 3 hours. OR 2 tablets COCs Mala D - 2 tablets stat repeated 12 hours within 72 hours
- Although emergency contraception is most efficacious if given within the first 72 hours, it can be given for up to 5 days after the assault.
- Pregnancy assessment must be done on follow up and the survivor must be advised to get tested for pregnancy in case she misses her next period.

Lacerations: Clean with antiseptic or soap and water. If the survivor is already immunized with Tetanus Toxoid or if no injuries, TT not required. If there are injuries and survivor is not immunized, administer ½ cc TT IM. If lacerations require repair and suturing, which is often the case in minor girls, refer to the nearest centre offering surgical treatment.

Post Exposure Prophylaxis (PEP) for HIV should be given if a survivor reports within 72 hours of the assault. Before PEP is prescribed, HIV risk should be assessed.

Follow-up: Please emphasize the importance of follow up to the survivor. It is ideal to call the survivor for re-examination 2 days after the assault to note the development of bruises and other injuries; thereafter at 3 and 6 weeks. All follow ups should be documented.

- Repeat test for gonorrhoea if possible.
- Test for pregnancy.
- Repeat after six weeks for VDRL.
- Assess for psychological sequelae and re-iterate need for psychological support as per section 5 of the guidelines.

Psychosocial care: All survivors should be provided the first line support. The health professional must provide this support himself/herself or ensure that there is someone trained at the facility to provide this. Refer to section VII for details.

Signature and seal

After the examination the medical practitioner should document the report, formulate opinion, sign the report and handover the report and sealed samples to police under due acknowledgement.

- On the last sheet, mention how many pages are attached. Each page of the report should be signed to avoid tampering.
- It is important that one copy of all documents be given to the survivor as it is his/her right to have this information. One copy to be given to the police and one copy must be kept for hospital records.
- **All evidence needs to be packed and sealed properly in separate envelopes.** The responsibility for this lies with the examining doctor. **All blood samples must be refrigerated until handed over** to next in chain of custody. The hospital has the responsibility of properly preserving samples till handed over to police.
- Each envelope must be labeled as follows

Packet number……………………………………………………………………………
Name of the hospital & place ………………………………………………………………
Hospital number & date ……………………………………………………………………
Police station with MLC number …………………….. ……………………………………
Name of the person with age & sex …………………………………………………………
Sample collected ………………………………………………………………………………
Examination required…………………………………………………………………………
Date & time signature of doctor with seal

- Chain of custody: The hospital must designate certain staff responsible for handling evidence and no one other than these persons must have access to the samples. This is done to prevent mishandling and tampering. If a fool-proof chain of custody is not maintained, the evidence can be rendered inadmissible in the court of law. A log of handing over of evidence from one 'custodian' to the other must be maintained.

Miscellaneous information

If a woman reports with a pregnancy resulting from an assault, she is to be given the option of undergoing an abortion, and protocols for MTP are to be followed. The products of conception (PoC) may be sent as evidence to the forensic lab (FSL) for establishing paternity / identifying the accused. The examining doctor/AMO/CMO is to contact the respective police station, ask them to collect the DNA Kit from the FSL and bring it to the hospital to coincide with the time of MTP. The DNA Kit is used to collect the blood sample of the survivor. The accompanying DNA Kit forms are to be filled by the examining doctor. A photograph of the survivor is required for this form, and should be arranged for prior to the MTP. The products of conception (PoC) are to be rinsed with normal saline (NOT completely soaked in saline) and collected in a wide-mouthed container with a lid. This sample is to be handed over immediately to the police along with the DNA Kit, or preserved at 4 degree Celsius. It is to be transported by the police in an ice-box, maintaining the temperature at around 4 degree Celsius (2 to 8 degree Celsius) at all times.

23. FINAL OPINION: To be formulated after receiving reports from the FSL

S.No.	Genital	Physical injuries/ diseases	FSL report injuries/ diseases	Final opinion
FOR PENILE PENETRATION				
1.	Present	Present	Positive for presence of semen	There are signs suggestive of forceful vaginal/anal intercourse.
2.	Present	Absent	Positive for presence of semen	There are signs suggestive of forceful vaginal/anal intercourse.
3.	Absent	Present	Positive for presence of semen	There are signs suggestive of forceful vagina/anal intercourse.
4.	Absent	Absent	Positive for presence of semen	There are signs suggestive of vagina/anal intercourse.
5.	Absent	Absent	Positive for drugs/ alcohol and semen	There are signs suggestive of vagina/anal intercourse under the influence of drugs/alcohol.
FOR NON-PENILE PENETRATION				
6.	Present	Present	FSL report is negative for presence of semen/ alcohol/ drugs/lubricant	There are no signs suggestive of vagina/anal intercourse, but there is evidence of physical and genital assault.
7.	Present	Absent	FSL report is negative for presence of semen/ alcohol/ drugs/ lubricant	There are no signs suggestive of vagina/anal intercourse, but there is evidence of genital assault.
8.	Absent	Present	FSL report is negative for presence of semen/ alcohol/ drugs/ lubricant	There are no signs suggestive of vagina/anal intercourse, but there is evidence of physical assault.
9.	Absent	Absent	FSL report is negative for presence of semen/ alcohol/ drugs/ lubricant	There are no signs suggestive of penetration of vagina/anal.
10.	Absent	Absent	FSL report is positive for presence of lubricant only	There is a possibility of vaginal/anal penetration by lubricated object.

OPINION FOR NON-PENETRATIVE ASSAULT

1.	Bite marks present and /or FSL detects salivary stains	There are signs suggestive of evidence of bite mark/s on ____________ site(time the injury)
2.	Sucking marks (discoid, subcutaneous extravasation of blood, with or without bite marks) present and /or FSL detects salivary stains	There are signs suggestive of sucking mark/s on ____________ site (time the injury).
3.	Forceful fondling, with presence of bruises or contusions with or without fingernail marks	There are signs suggestive of forceful physical injuries on ____________ site (time the injury) (which may be due to fondling)
4.	Only forceful kissing and FSL detects salivary stains	There are signs suggestive of salivary contact (which may be due to kissing)
5.	If the history suggests forced masturbation of the assailant by the survivor and if there is evidence of seminal stains detected on the hands	There are signs suggestive of the survivor of seminal fluid contact (which may be due to masturbation)
6.	In case there are no signs of sucking, licking…… detected, but the history suggests some such form of assault	It is still important to document a good history because the survivor may have had a bath or washed him/herself.

PSYCHO–SOCIAL CARE FOR SURVIVORS/VICTIMS

Clinical guidelines for responding to IPV and sexual assault, WHO, 2013:

Health-care providers should, as a minimum, offer first-line support when women disclose violence. First Line support includes:

- *Ensuring consultation is conducted in private.*
- *Ensuring confidentiality, while informing women of limits of confidentiality.*
- *being non-judgmental and supportive and validating what the woman is saying.*
- *providing practical care and support that responds to her concerns, but does not intrude*
- *asking about her history of violence, listening carefully, but not pressuring her to talk (care should be taken when discussing sensitive topics when interpreters are involved)*
- *helping her access information about resources, including legal and other services that she might think helpful*
- *assisting her to increase safety for herself and her children, where needed*
- *providing or mobilizing social support-*

If doctors are unable to provide first-line support, they should ensure that someone else at the health facility is available to do so.

A set of guidelines based on the above:

Creating an enabling atmosphere and establishing trust

The health professional should

- Speak to survivor in a private space
- Recognize her courage in reaching you as she has overcome several barriers
- Recognise the dilemma faced by survivor in reporting violence. Do not label non-reporting to police as false case.
- Assure the survivor that her treatment will not be compromised
- Inform survivor of available resources, referrals, legal rights so that she can take an informed decision.

a. Sexual violence is known to cause physical, emotional social and economic consequences which can jeopardize the well-being of survivors and their families. Fear of police investigation procedures, shame related to the sexual violence, lack of support from the community, fear that nobody will believe them and lack of information about negative health consequences may lead survivors to hide such incidents.
b. Reasons for not wanting to report to police could range from fear about community reactions, fear that nobody would believe them, feelings of shame, threats from perpetrators. With children there could also be a possibility that survivor has not disclosed the assault to parents/guardians.

Facilitation and demystification of medical procedures

The health professional should:

- Prepare the survivor for an internal examination.
- Explain the various stages of the examination.
- Communicate the rationale for referral for X-ray, USG, age estimation amongst others.
  a. Any incident of sexual violence leads to a feeling of powerlessness amongst survivors. It is therefore important to recognize such covert feelings and explain the purpose of medical examination. Explaining the purpose of internal examination and steps in conducting it can help survivors to make sense of what is happening to them. This can help in regaining control over the situation.
  b. Currently each health setting may not have all the infrastructure for additional services such as age estimation, laboratory for assessing infections, sonography machines to detect internal injuries/ pregnancy and so on. While making referrals providers must ensure confidentiality and privacy of survivors so that they are not embarrassed due to being identified as a “survivor of sexual violence”.

Addressing survivor’s emotional wel-being

The health professional should:

- Recognise that survivors may present varied emotions.
- Encourage the survivor to express her feelings.
- Encourage survivors to seek crisis counseling.
- Assess for suicidal ideation.
- Make a safety assessment and safety plan.
- Involve family and friends in healing process of survivor.

a. Each survivor copes with the assault differently. Coping is also dependent on whether survivors have parental/ spousal support, community support, job security, economic wherewithal for litigation and several such factors.
b. Most survivors may not openly express their feelings. A good starting point is to explain range of feelings that survivors may experience such as sleeplessness, anxiety, nervousness, crying spells, feelings of ending one's life, anger and flash backs (RTS, emotional reactions post rape) after an assault. It must also be discussed that such reactions are normal after a traumatic episode.
c. Crisis counseling can help in overcoming trauma. Providers must explain to the survivors that:

i. “rape” is a violation of bodily integrity and not a loss of honour.
ii. Assault is an abuse of power and not an act of lust.
iii. Positive messaging such as “you are not responsible for rape”, “It is not about the clothes you wear”
iv. This would enable the survivor to discard feelings of self-blame as it is the perpetrator who should feel ashamed about the act and help in rebuilding survivor's confidence in self.

Safety assessment must be done:

If assessment reveals that she is unsafe and fears reoccurrence of sexual violence health professional must offer her alternate arrangements for stay such as temporary admission in the hospital or referral to shelter services. However some survivors may want to go home particularly if there are children or other dependents. A safety plan must be made which may include suggestions such as making a police complaint about threats received, building support strategy with neighbours/ community and temporary relocation from the old residence.

In situations, where a parent is the perpetrator of sexual abuse:

Survivors under 18 years, are likely to be accompanied by parents / guardians. If a health professional finds out that the perpetrator is the parent, it is critical to involve social worker/counselor from the hospital to discuss safety of the child. As per POCSCO Act, 2012 social worker would have to speak with the child to assess whom the child trusts and can be called upon in the hospital itself. Simultaneously social worker would also have to contact police, who in communication with social worker should assess whether the child is in need of protection and care. Likewise the child may be admitted to the hospital for a period of 24 hours till a long term strategy for shelter or child welfare home is made.(Chapter 5, Procedure on reporting offence , POCSCO Act, 2012)

Role of family, friends and community :

- Recovery from sexual violence is dependent on the extent of support received from family, friends and community. Health professionals are best suited to engage with family and discuss ways of promoting survivors' well-being. It must be discussed with all care givers that survivor should not be held responsible for the assault. Judgments such as; “she should have been careful”, “she should have resisted” make the survivors journey to recovery more difficult.

In situations of child sexual abuse :

Parents may experience anger, confusion, and guilt. Some may also blame themselves for not having taken adequate care or paid attention to the child. Reiterate that it is the perpetrator who misused their position.

Messages such as:

- Believe that recovery from abuse is possible
- Strategies such as good touch and bad touch can be taught to the child from a very young age, so that if the child is touched inappropriately, she should raise an alarm.
- Restricting child's mobility such as not being allowed to play with friends, not allowed to go to school, not allowed to visit friends, may be perceived by the child as punishment for something the child had no control on.
- Encourage the child to carry on with his/ her daily routine.
- Follow up with crisis counselling so that the child is able to deal with negative feelings and also heal from the abuse.

Dealing with adolescents:

- In cases of adolescent survivors, communicate that she was not at fault, encourage her to share feelings, fears and concerns. For an adolescent, acceptance by family and peers becomes a critical aspect in healing.
- Parents and friends should encourage survivor to seek counselling and crisis intervention support as adolescence is an age of turbulence and the survivor may not be comfortable talking about several issues with parents / carers such as “contraception”, “health sexual relationships”, fears of contracting infections such as STI/HIV, anxiety about how they are perceived by others in the school/ college.
- Carers should exercise caution and not become over protective and restrictive in their approach. This could occur due to fear of recurrence of the assault and fear for survivor's safety. These concerns need to be discussed openly with the survivor and encourage her to make informed decisions.

GUIDELINES FOR INTERFACE WITH OTHER AGENCIES SUCH AS POLICE AND JUDICIARY

Health professionals have to interface with other agencies such as the police, public prosecutors, judiciary and child welfare committees to ensure comprehensive care to survivors of sexual violence. Specific guidelines have been provided in this section for this interface for smooth interagency coordination.

Interface of health systems with police

- A standard operating procedure outlining the interface between the police and health systems is critical. Whenever a survivor reports to the police, the police must take her/him to the nearest health facility for medical examination, treatment and care[1]. Delays related to the medical examination and treatment can jeopardize the health of the survivor.
- Health professionals should also ask survivors whether they were examined elsewhere before reaching the current health set up and if survivors are carrying documentation of the same .If this is the case , health professionals must refrain from carrying out an examination just because the police have brought a requisition and also explain the same to them
- The health sector has a therapeutic role and confidentiality of information and privacy in the entire course of examination and treatment must be ensured. The police should not be allowed to be present while details of the incident of sexual violence, examination, evidence collection and treatment are being sought from the survivor.
- The police cannot interfere with the duties of a health professional. They cannot take away the survivor immediately after evidence collection but must wait until treatment and care is provided.
- In the case of unaccompanied survivors brought by the police for sexual violence examination, police should not be asked to sign as witness in the medico legal form. In such situations, a senior medical officer or any health professional should sign as witness in the best interest of the survivor.
- Health professionals must not entertain questions from the police such as "whether rape occurred", "whether survivor is capable of sexual intercourse", "whether the person is capable of having sexual intercourse". They should explain the nature of medico legal evidence, its limitations as well as the role of examining doctors as expert witnesses.

[1]CLA, 2013 and POCSCO Act, 2012 both recognize that any registered medical practitioner can carry out a medico legal examination and provide treatment and records of that health provider will stand in the court of law(164A CRPC).

Interface of health systems and public prosecutors

- The doctor must review the notes of the case to equip him/herself with the history that has been provided by the survivor to the doctor, the police and the magistrate. In case there is a difference in the histories, the same should be clarified in advance with the public prosecutor. It is possible that a survivor revealed additional information to the doctor based on her comfort, than the police or the magistrate.
- Examining doctors should prepare themselves well in time with the case documents before reaching the court. Efforts must be made by doctors to dialogue with the public prosecutor and also ask them about the role that they need to play. This would help them to be well prepared and respond to questions asked in the court.

Interface of health systems and the judiciary

- Doctors are termed as “expert witness” by Law. As per 164 A, Cr.P.C., an examining doctor has to prepare a reasoned medical opinion without delay.
- A medical opinion has to be provided on the following aspects –
    - Evidence that survivor was administered drugs/psychotropic substance/alcohol, etc;
    - Evidence that the survivor has an intellectual, or mental disability;
    - Evidence of physical health consequences such as bruises, contusions, contused lacerated; wounds, tenderness, swelling, pain in micturition, pain in defecation, pregnancy, etc.
    - Age of the survivor if she / he does not have a birth certificate or if mandated by the court.
- Absence of injuries on the survivor has to be interpreted by the examining doctor in the courtroom based on medical knowledge and details of the episode provided by survivor to the doctor. Lack of injuries have to be based on the time lapse between the incident and reporting to hospitals, information pertaining to luring the child or adult survivor, or factors such as fear, shock and surprise or other circumstances that rendered the child or adult survivor unable to resist the perpetrator.
- The examining doctor will also have to provide a medical opinion on negative findings related to forensic lab analysis. Absence of negative laboratory results may be due to:
    - Delay in reaching a hospital / health centre for examination and treatment;
    - Activities undertaken by the survivor after the incident of sexual violence such as urinating, washing, bathing, changing clothes or douching which leads to loss of evidence;
    - Use of condom/vasectomy or diseases of vas of the perpetrator, or
    - Perpetrator did not emit semen if it was a penile penetrative sexual act.
- The examining doctor should clarify in the court that normal examination findings neither refute nor confirm whether the sexual offence occurred or not. They must ensure that a medical opinion cannot be given on whether 'rape' occurred because 'rape' is a legal term.

- Examining doctors must also ensure that comments on past sexual history, status of vaginal introitus must not be made as these are unscientific and the courts too have determined them as biased.
- In most health centres because of the constant turnover, the doctor appearing in the court room could be different from the one who carried out the medical management of the survivor. In such instances, it is critical that the doctor making the court appearance be thorough with the case file of the survivor, such as, documentation of history examination findings and clinical inference drawn by the examining doctor.

Interface of the health system with the child welfare committee

- Health professionals should communicate to the child the need for her/him (health professional) to disclose the abuse to the child welfare committee (CWC) so that the latter can take immediate steps to protect the child from abuse.
- Children may be referred for examination by the child welfare committees (CWC). Health professionals may have to orient the CWC about the health consequences of sexual abuse and the importance of provision of complete health care. At the same time they must explain the limitations of medical evidence, thus even if medical evidence of sexual violence is not found, this in no way should be construed as a child lying about sexual abuse.
- Mobile care units (MCUs) must include indicators for assessing whether a child has been subjected to sexual violence. Such an enquiry must be included as a component of routine medical checkups. A standard operating procedure for routine medical examination, care and management must be adopted by all child welfare homes and they must be asked to provide reports of these assessments to the child welfare committee. Health professionals may be called upon for doing this.

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Abbreviation

AIDS	Acquired immunodeficiency syndrome
AMO	Assistant Medical Officer
CEDAW	Convention on the Elimination of Discrimination against Women
CLA, 2013	Criminal Law (Amendment) Act, 2013
CMO	Chief Medical Officer
CRC	Convention of the Rights of the Child
Cr. PC	Code of Criminal Procedure
CRPD	Convention on the Rights of Persons with Disabilities
CWC	Child Welfare Committee
DNA	Deoxyribonucleic acid
EDTA	Ethylenediaminetetraacetic acid
FIR	First Information Report
FSL	Forensic Science Laboratory
HIV	Human immunodeficiency Virus (HIV)
ICESCR	International Covenant on Economic, Social and Cultural Rights
IO	Investigating Officer
IPC	Indian Penal Code
IPD	Indoor Patient Department
IPV	Intimate Partner Violence
JVC	Justice Verma Committee
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MCUs	Mobile Care Units
MLC	Medico Legal Case
MTP	Medically Termination of Pregnancy
OPD	Outdoor Patient Department
POCSO Act, 2012	Protection of Children from Sexual Offences, 2012
PEP	Post exposure prophylaxis
PoC	Products of Conception
RMP	Registered Medical Practitioner
RTS	Rape Trauma Syndrome
SAFE	Sexual Assault Forensic Evidence
SOP	Standard Operating Procedure
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
TG/IS	Transgender and intersex persons
UPT	Urine Pregnancy test
USG	Ultrasonography
VDRL	Venereal Disease Research Laboratory
WHO	World Health Organization

Annexure 1

Legal definitions

List of offences under the IPC and Criminal Law Amendment Act 2013 and the punishment for the offence

Sr. No	Offence and description	Punishment
1.	**Section 354 :** Assault or criminal force to woman with intent to outrage her modesty	Imprisonment not less than 1 year but which may extend to 5 years and fine .
2.	**Section 354 A** (1): Sexual Harassment: A man committing any of the following acts: (i) Physical contact or advances which include unwanted sexual overtures, (ii) Request for sexual favours, (iii) Showing pornography against will, (iv) Making sexually coloured remarks.	**Section 354 A** (2): An offence specified in clause (i), (ii) or (iii) of sub-section (1) shall be punished with imprisonment which may extend to three years and/or fine. **Section 354 A** (3): An offence specified in clause (iv) of sub-section (1) shall be punished with imprisonment which may extend to one year and/or fine.
3.	**Section 354 B**: assault or use of criminal force to any woman or abetment to such act with the intention of disrobing or compelling her to be naked.	**Section 354 B**: imprisonment for a term not less than three years but which may extend to seven years, and shall also be liable to fine.
4.	**Section 354 C**: Voyeurism - Any man who watches, captures or disseminates the image of a woman engaging in a private act in circumstances where she would usually have the expectation of not being observed.	**Section 354 C**: on first conviction: imprisonment for a term not less than one year, but which may extend to three years, and fine. On a second or subsequent conviction: imprisonment of for a term not less than three years, but which may extend to seven years, and fine.
5.	**Section 354 D**: **Stalking** (1) Any man who: (i) follows a woman and contacts, or attempts to contact such woman repeatedly despite a clear indication of disinterest or (ii) monitors the use by a woman of the internet, email or any other form of electronic communication. Such conduct shall not amount to stalking if (i) it was pursued for the purpose of preventing or detecting crime by a man entrusted with such responsibility by the State (ii) it was pursued under any condition or requirement imposed by any person under any law; or (iii) in the particular circumstances such conduct was reasonable and justified.	On first conviction: with imprisonment for a term which may extend to three years, and fine. On a subsequent conviction: with imprisonment for a term which may extend to five years, and fine.

6.	**Section 375 - Rape:** A man is said to commit "rape" if he— a) penetrates his penis, to any extent, into the vagina, mouth, urethra or anus of a woman or makes her to do so with him or any other person; or b) inserts, to any extent, any object or a part of the body, not being the penis, into the vagina, the urethra or anus of a woman or makes her to do so with him or any other person; or c) manipulates any part of the body of a woman so as to cause penetration into the vagina, urethra, anus or any part of body of such woman or makes her to do so with him or any other person; or d) applies his mouth to the vagina, anus, urethra of a woman or makes her to do so with him or any other person, under the circumstances falling under any of the following seven descriptions:— First.—Against her will. Secondly.—Without her consent. Thirdly.—With her consent, when her consent has been obtained by putting her or any person in whom she is interested, in fear of death or of hurt. Fourthly.—With her consent, when the man knows that he is not her husband and that her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married. Fifthly.—With her consent when, at the time of giving such consent, by reason of unsoundness of mind or intoxication or the administration by him personally or through another of any stupefying or unwholesome substance, she is unable to understand the nature and consequences of that to which she gives consent. Sixthly.—With or without her consent, when she is under eighteen years of age. Seventhly.—When she is unable to communicate consent.	**Section 376 (1)**: Anyone who commits rape shall be punished with rigorous imprisonment which shall not be less than seven years, but which may extend to imprisonment for life, and shall also be liable to fine.

	Explanation 1.—For the purposes of this section, "vagina" shall also include labia majora. Explanation 2.—Consent means an unequivocal voluntary agreement when the woman by words, gestures or any form of verbal or non-verbal communication,communicates willingness to participate in the specific sexual act: Provided that a woman who does not physically resist to the act of penetration shall not by the reason only of that fact, be regarded as consenting to the sexual activity. Exception 1.—A medical procedure or intervention shall not constitute rape. Exception 2.—Sexual intercourse or sexual acts by a man with his own wife, the wife not being under fifteen years of age, is not rape	
7.	**Section 376 (2)** In certain situations, the punishment for rape increases. These situations include: When rape is committed a) by a police officer within the limits of the police station to which such police officer is appointed; in the premises of any station house; on a woman in such police officer's custody or in the custody of a police officer subordinate to such police officer b) by a public servant, commits rape on a woman in such public servant's custody c) by a member of the armed forces deployed in an area by the Central or a State Government commits rape in such area d. by management or on the staff of a jail, remand home or other place of custody commits rape on any inmate of such jail, remand home, place or institution; or e) by management or on the staff of a hospital, commits rape on a woman in that hospital; or	**Section 376 (2)** Punishment not less than ten years, but may extend to imprisonment for life, which shall mean imprisonment for the remainder of that person's natural life, and shall also be liable to fine.

	f) by a relative, guardian or teacher of, or a person in a position of trust or authority towards the woman, commits rape on such woman; or g) during communal or sectarian violence h) on a woman who is pregnant, I) on a woman who is under sixteen years of age, j) on a woman who is incapable of giving consent; k) by a person being in a position of control or dominance over a woman l) on a woman who is suffering from mental or physical disability; When rape causes grievous bodily harm or maims or disfigures or endangers the life of a woman; When a man commits rape repeatedly on the same woman.	
8.	**Section 376 (A)** If in the course of commission of an offence under 376 (1) and (2), the man inflicts an injury which causes the death of the woman or causes the woman to be in a persistent vegetative state.	**Section 376 (A)** If in the course of commission of an offence under 376 (1) and (2), the man inflicts an injury which causes the death of the woman or causes the woman to be in a persistent vegetative state.
9.	**Section 376 (B)**: Non-consensual sexual intercourse with wife during separation: Whoever has sexual intercourse with his own wife, who is living separately, whether under a decree of separation or otherwise, without her consent	**Section 376 (B)** Imprisonment for a term not less than two years but which may extend to seven years, and fine.
10.	**Section 376 (C)** Whoever, being in a position of authority or in a fiduciary relationship; or a public servant; or superintendent or manager of a jail, remand home or children's institution; or on the management or staff of a hospital abuses such position or fiduciary relationship to induce or seduce any woman under his charge or present to have sexual intercourse with him, such sexual intercourse not amounting to the offence of rape.	**Section 376 (C)** Rigorous imprisonment for a term not less than five years, but which may extend to ten years, and fine.

11.	**Section 376 (D): Gang Rape** Where a woman is raped by one or more persons constituting a group or acting in furtherance of a common intention, each of those persons shall be deemed to have committed the offence of rape.	**Section 376 (D)** Rigorous imprisonment for a term not less than twenty years, but which may extend to life which shall mean imprisonment for the remainder of that person's natural life, and fine.
12.	**Section 376 (E)**: **Repeat Offenders** Whoever has been previously convicted of an offence punishable under section 376 or section 376A or section 376D and is subsequently convicted.	**Section 376 (E)**: Imprisonment for life or death.

List of offences under the Protection of children from Sexual Offences Act 2012 (POCSO) and the punishment for the offence

Sr. No	Offence and description	Punishment
1.	**Section 3:** Penetrative Sexual Assault is defined as – • penetration of the penis to any extent into any vagina, urethra, or anus of a child's body, • insertion of an object to any extent into the vagina, urethra, or anus of a child, • manipulating the body of a child so as to cause penetration into the vagina, urethra or anus, and applying the mouth to the vagina, penis, anus or urethra of a child or making a child do any of the above with him or any other person.	**Section 4:** Not less than seven years of imprisonment which may extend to imprisonment for life, and liable to be fined.
2.	**Section 5:** Aggravated Penetrative Sexual Assault- Penetrative sexual assault by a police officer, member of armed forces, public servant, management or staff of remand home, jail, protection home, observation home, hospital (whether government or private) or management or staff of educational or religious institution. It includes penetrative sexual assault committed by any other person: through gang penetrative assault, penetrative sexual assault using deadly weapons, fire, heated substance or corrosive substance, penetrative sexual assault which physically incapacitates the child or causes child to become mentally ill or causes impairment of any kind so as to render the child unable to perform regular tasks temporarily or permanently, causing grievous harm or bodily hurt and injury or injury to the sexual organs of the child, making girl child pregnant as a consequence of sexual assault, inflicting child with HIV or any other life threatening disease or infection, penetrative sexual assault taking advantage of the child's mental or physical disability, penetrative sexual assault more than once, penetrative	**Section 6:** Not less than ten years of imprisonment which may extend to imprisonment for life, and liable to fine

	sexual assault on a child younger than 12 years, by a relative of the child through blood or adoption or marriage or guardianship or in foster care or having a domestic relationship with the parent of the child or who is living in the same or shared household with the child, by the owner / manager or staff of any institution providing services to the child, by a person in a position of trust or authority over the child in an institution or home of the child or anywhere else, committing penetrative sexual assault knowing the child is pregnant, committing penetrative sexual assault on a child and attempt to murder the child, penetrative sexual assault in the course of communal or sectarian violence, by a person previously convicted of having committed any offence under this act or any sexual offence punishable under any other law for the time being in force, penetrative sexual assault and making the child strip or parade naked in public.	
3.	**Section 7:** Sexual Assault includes - Touching the vagina, penis, anus or breast of the child with sexual intent or making the child touch the vagina, penis, anus or breast of such person or any other person, Any other act with sexual intent which involves physical contact without penetration.	**Section 8:** Not less than three years of imprisonment which may extend to five years, and liable to fine.
4.	**Section 9:** Aggravated Sexual Assault - Sexual assault by a police officer, member of armed forces, public servant, management or staff of remand home, jail, protection home, observation home, management or staff of hospital (whether government or private) or management or staff of educational or religious institution. It includes other acts of sexual assault by any person or in other circumstances as mentioned in the second part of section 5, except making a girl child pregnant.	**Section 10:** Not less than five years of imprisonment which may extend to seven years, and liable to fine.
5.	**Section 11:** Sexual Harassment of the Child-With sexual intent: Utters any word or makes any sound, or makes any gesture or exhibits any object or part of body with the intention that such	**Section 12:** Up to three years of imprisonment and liable to fine.

	word or sound shall be heard, or such gesture or object or part of body shall be seen by the child; or makes a child exhibit his body or any part of his body so as it is seen by such person or any other person; or shows any object to a child in any form or media for pornographic purposes; or repeatedly or constantly follows or watches or contacts a child either directly or through electronic, digital or any other means; or threatens to use, in any form of media, a real or fabricated depiction through electronic, film or digital or any other mode, of any part of the body of the child or the involvement of the child in a sexual act; or entices a child for pornographic purposes or gives gratification therefore.	
6.	**Section 13:** Use of Child for Pornographic Purposes: use of child in any form of media (including program or advertisement telecast by television, internet or electronic or printed form, whether or not such program or advertisement is intended for personal use or for distribution), for the purpose of sexual gratification which includes representation of the sexual organs of the child, usage of a child engaged in real or simulated sexual acts (with or without penetration), indecent or obscene representation of a child.	**Section 14 (1):** Imprisonment up to five years and fine and in the event of subsequent conviction, up to seven years and fine.
7.	**Section 14 (2):** Penetrative sexual assault (Section 3) by directly participating in pornographic acts.	**Section 14 (2):** Not less than ten years of imprisonment, which may extend to imprisonment for life, and fine.
8.	**Section 14 (3):** Aggravated penetrative sexual assault (Section 5) by directly participating in pornographic acts.	**Section 14 (3)**: Rigorous imprisonment for life and fine.
9.	**Section 14** (4): Sexual assault (Section 7) by directly participating in pornographic acts.	**Section 14** (4): Not less than six years of imprisonment which may extend to eight years, and fine.
10.	**Section 14** (5): Aggravated sexual assault (Section 9) by directly participating in pornographic acts.	**Section 14** (5): Not less than eight years of imprisonment which may extend to ten years, and fine.

11.	**Section 15:** Storage of pornographic material in any form, involving a child for commercial purposes.	**Section 15:** Three years of imprisonment and / or fine.
12.	**Section 16: Abetment of an offence:** A person abets an offence if he • Instigates any person to do that offence • Engages with one or more other person/s in any conspiracy for the doing of that offence, if an act or illegal omission takes place in pursuance of that conspiracy, and in order to the doing of that offence Intentionally aids, by any act or illegal omission, the doing of that offence.	**Section 17:** If the act abetted is committed in consequence of the abetment, the person shall be punished with punishment provided for that offence.
13.	**Section 18:** Attempt to commit an offence	**Section 18:** Imprisonment of any description provided for the offence for a term which may extend to one half of the imprisonment for life, or one half of the longest term of imprisonment provided for that offence and/or with fine.
14.	**Section 21**: Punishment for failure to report or record a case by (i) Any person; (ii) Any person, being in charge of any company or an institution. (This offence does not apply to a child).	**Section 21** (i) Imprisonment of either description which may extend to six months or with fine or with both, (ii) Any person, being in charge of any company or an institution (by whatever name called) who fails to report the commission of an offence under sub section (1) of section 19 in respect of a subordinate under his control shall be punished with imprisonment for a term which may extend to one year and with fine.
15.	**Section 22:** (1) Punishment for false complaint or false information in respect of an offence committed under sections 3, 5, 7 and section 9 solely with the intention to humiliate, extort or threaten or defame him. (3) False complaint or providing false information against a child knowing it to be false, thereby victimising such child in any of the offences under this Act. (This offence does not apply to a child)	**Section 22:** (1) Imprisonment for a term which may extend to six months or with fine or with both. (3) Imprisonment which may extend to one year or with fine or with both.

Annexure 2

Time since injury is as follows:

Abrasion

Fresh	Bright red
12 to 24 hours	Reddish scab
2 to 3 days	Reddish brown scab
4 to 7 days	Brownish black scab
After 7 days	Scab dries, shrinks and falls off from periphery

Contusion

Fresh	Red
Few hours to 3 days	Blue
4th day	Bluish black to brown (haemosiderin)
5 to 6 days	Greenish (haematoidin)
7 to 12 days	Yellow (bilirubin)
2 weeks	Normal

Note: This is a reference chart only, as many external and internal factors contribute in the healing of injuries.

If there is deep bruise or contusion, signs of injury will usually show after 48 hours. In case you see signs of injury on the follow up, please record them and attach the documentation to MLC papers.

Laceration: It becomes difficult to estimate exactly the time since injury based on the size and contamination. However, a rough estimate can be done based on signs of healing.

Incised injury:

Fresh	Hematoma formation
12 hours	Edges- red, swollen
24 hours	Scab of dried clot covering the entire area.
After this rough estimate can be based on signs of healing.	

Please do not mention old scars as they are identification marks rather than new injuries due to assault. If mentioning those seems pertinent, add a note on when they were acquired.

Annexure 3

Age estimation

Please bear in mind that age estimation is not required in every case. If there is enough documentary proof, age determination is not required

- Medical age is the mean of physical age, dental age and radiological age of the person.
- Physical age is estimated based on physical growth like height, weight, chest circumference etc and also based on secondary sexual characteristics.
- Tanner staging of breast and pubic hair should be used to determine stage of growth.

Breast Development using Tanner's Index:		
Stage 1	Pre- adolescent: Elevation of papilla only	Less than 9 years
Stage 2	Breast bud stage: Elevation of breast and papillaas a small mound. Enlargement of areola diameter	10-11 years
Stage 3	Further enlargement and elevation of breast and areola with no separation of their contours	12 years
Stage 4	Projection of areola and papilla to form a secondary mound above level of breast	13-14 years
Stage 5	Mature stage: projection of papilla only due to recession of the areola to general contour of breast	15-16 years

Pubic hair staging		
Stage 1	Preadolescent: Vellus over pubes is not further developed than that over the abdominal wall (ie. No pubic hair)	Less than 12 years
Stage 2	Sparse growth of long, slightly pigmented downy hair, straight or slightly curled, chiefly along the labia	12-13 years
Stage 3	Considerably darker hair, coarser, more curled. Hair spreading sparsely over the junction of the pubes	13-14 years
Stage 4	Hair now adult in type, but area covered is still considerably smaller than in adult. No spread over medial surface of thighs.	14-15 years
Stage 5	Adult in quantity and type with distribution to horizontal pattern. Spread to medial surface of thighs.	More than

Dental age is estimated by identifying the total number of teeth, how many and which among them are temporary and which are permanent. It is also essential to identify which is the last tooth erupted and based on charts we can estimate the dental age by noting the age corresponding to the tooth last erupted.

Count the total number of teeth and also differentiate which of them are temporary or permanent.

1. P - for permanent
2. T - for temporary
3. y - for erupted
4. X - not erupted

Eruption of teeth

Temporary teeth (Rule of halves)

- Lower central incisors - 5 to 6 months
- Upper central incisors - 6 to 7 months
- Upper lateral incisors - 7 to 8 months
- Lower lateral incisors - 8 to 9 months
- First molars - 1 year
- Canines - 1 ½ years
- Second molars - 2 to 2 ½ years

Permanent teeth

- First molars - 6 to 7 years
- Central incisors - 7 to 8 years
- Lateral incisors - 8 to 9 years
- First premolars - 9 to 10 years
- Second premolars - 10 to 11 years
- Canines - 11 to 12 years
- Second molars - 12 to 14 years
- Third molars - 17 to 25 years

Temporary teeth	Permanent teeth
Smaller	Larger
Shiny	Lusterless
Vertical upper incisors	Forward & downward upper incisors
Smooth incisor edge	Serrated incisor edge
Worn out cusps in molars	Prominent cusps in molars
Twenty - 2102 (Incisor, Canine, premolar, molar)	Thirty two - 2123 (Incisor, Canine, premolar, molar)

Note: This a reference chart only, as many external and internal factors contribute in the eruption of teeth.

Radiological age:

Radiological age is estimated by looking for appearance of ossification centers, fusion of those with the shaft, fusion of sutures etc. for this we have to take radiographs of various joints to look for these findings of ossification centers.

Important changes at various ages in joints visible radiologically.

12 years	Hip joint (center for lesser trochanter appears 10 to 12 yrs) Elbow joint (center for lateral epicondyle appears 11 to 12 yrs) Wrist joint (center for pisiform appears 10 to 12 years)
14 years	Hip joint (center for iliac crest appears 14 yrs) Elbow joint (center for radial tuberosity appears 14yrs)
16 years	Hip joint (center for ischial tuberosity appears 16 yrs)
18 years	Shoulder joint (all centers of upper end of humerus fuse with shaft) Wrist joint (all centers of lower end of radius and ulna fuse with shaft) Hip joint (center for iliac crest fuses with ilium)
21 years	Hip joint (center for ischial tuberosity fuses with the ischial body)

Note: This is a reference chart only, as many external and internal factors contribute in the fusion of ossification centers.

Annexure 4

Table indicative of type of evidence to be collected

History of sexual violence	Type of swab	Purpose	Points to consider
Peno-vaginal	Vaginal swabs	- Semen/sperm detection - lubricant - DNA	- whether ejaculation occurred inside vagina or outside - use of condom
	Body swabs	- semen/sperm detection - saliva (in case of sucking/licking)	- if ejaculation occurred outside
Peno anal	Anal swabs	- Semen/sperm detection - DNA - lubricant - faecal matter	- whether ejaculation occurred inside anus or outside - use of condom
	Body swabs	- semen/sperm detection - saliva (in case of sucking/licking)	- if ejaculation occurred outside
Peno oral	Oral swabs	- Semen/sperm detection - DNA - saliva	- whether ejaculation occurred inside mouth or outside - use of condom
	Body swabs	- semen/sperm detection - saliva (in case of sucking/licking)	- if ejaculation occurred outside
Use of objects	Swab of the orifice (anal, vaginal and/or oral)	Lubricant	Detection of lubricant used if any
Use of body parts (fingering)	Swab of the orifice (anal, vaginal and/ or oral)	Lubricant	
Masturbation	Swab of orifice/body part	- Semen/sperm detection - DNA - lubricant	- whether ejaculation occurred or not - if ejaculated in orifice or body parts

Forensic evidence is likely to be found only upto 96 hours after the incident.

PART II

PROFORMA FOR MEDICO-LEGAL EXAMINATION OF SURVIVORS/VICTIMS OF SEXUAL VIOLENCE

ONE PAGE INSTRUCTIONS FOR DOCTORS

The examining doctor should carefully read the Guidelines for responding to survivors of sexual violence issued by the MoHFW, and should be well aware of the comprehensive care to be provided.

1. **Informed consent:** Doctors shall inform the person being examined about the nature and purpose of examination and in case of child to the child's parent/guardian/person in whom the child reposes trust. This information should include:

a. The medico-legal examination is to assist the investigation, arrest and prosecution of those who committed the sexual offence. This may involve an examination of the mouth, breasts, vagina, anus and rectum.

b. To assist investigation, forensic evidence may be collected with the consent of the survivor. This may include removing and isolating clothing, scalp hair, foreign substances from the body, saliva, pubic hair, samples taken from the vagina, anus, rectum, mouth and collecting a blood sample.

c. The survivor or in case of child, the parent/guardian/person in whom the child reposes trust, has the right to refuse either a medico-legal examination or collection of evidence or both, but that refusal will not be used to deny treatment to survivor after sexual violence.

d. As per the law, the hospital/ examining doctor is required to inform the police about the sexual offence. However, if the survivor does not wish to participate in the police investigation, it will not result in denial of treatment for sexual violence. Informed refusal will be documented in such cases.

2. Per vaginum examination, commonly referred to by lay persons as 'two-finger test', must not be conducted for establishing an incident of sexual violence and no comment on the size of vaginal introitus, elasticity of the vagina or hymen or about past sexual experience or habituation to sexual intercourse should be made as it has no bearing on a case of sexual violence. No comment on shape, size, and/or elasticity of the anal opening or about previous sexual experience or habituation to anal intercourse should be made.

3. Injury documentation: Examine the body parts for sexual violence related findings (such as injuries, bleeding, swelling, tenderness, discharge). This includes both micro mucosal injuries which may heal within short period to that of severe injuries which would take longer to heal. Please refer to section VI Point 17 of the Guidelines.

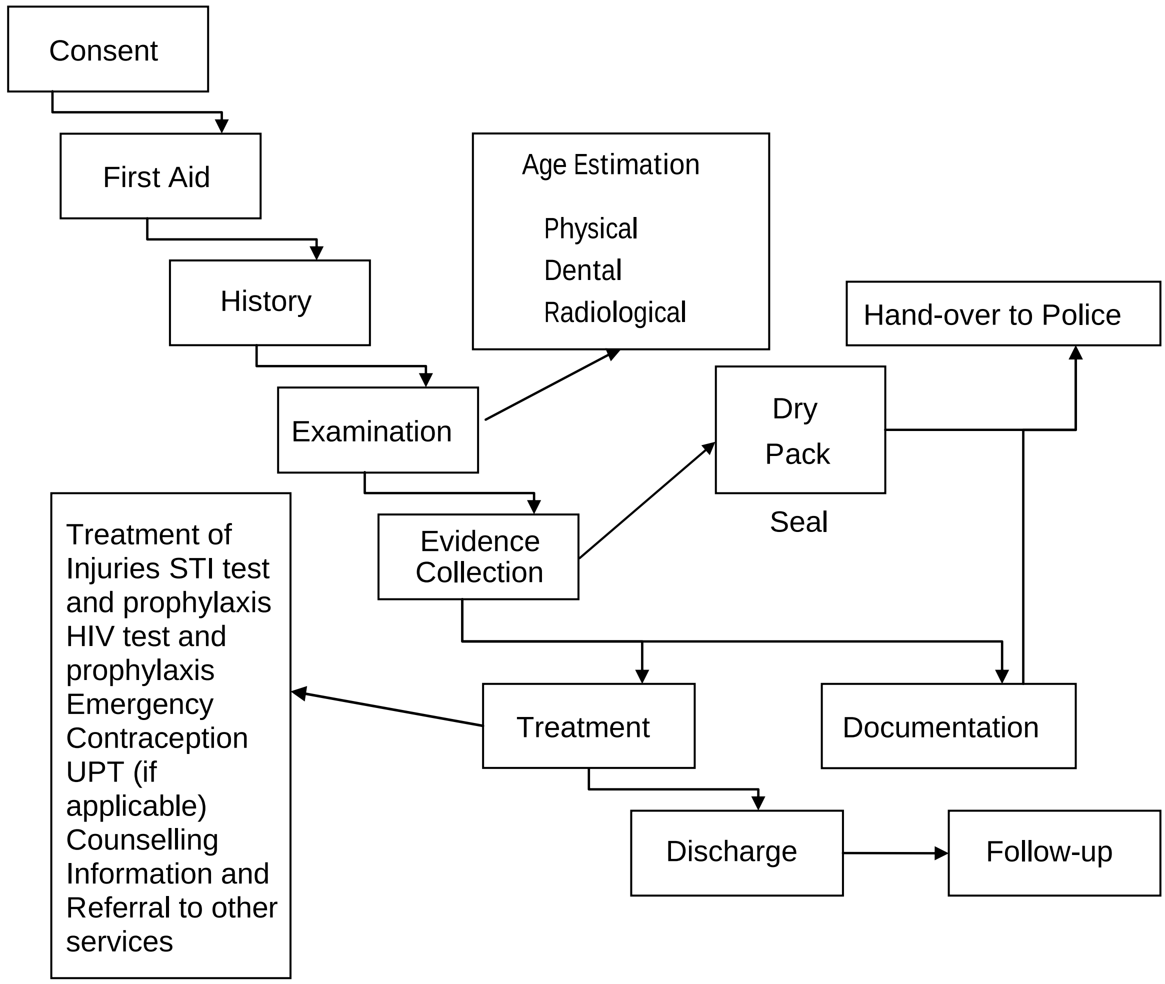
- Injuries must be recorded with details - size, site, shape, colour.
- If a past history of sexual violence is reported, then record relevant findings. Sexual violence is largely perpetrated against females, but it can also be perpetrated against males, transgender and intersex persons.

4. The nature of forensic evidence collected will be determined by three main factors- nature of sexual violence, time lapsed between incident of sexual violence and examination and whether survivor has bathed or washed herself. Please refer to Section VI Point 21of Guidelines.

5. Opinion: The issue of whether an incident of rape/sexual assault occurred is a legal issue and not a medical diagnosis. Consequently, doctors should not, on the basis of the medical examination conclude whether rape/sexual assault had occurred or not. Only findings in relation to medical findings should be recorded in the medical report.

- Drafting of provisional opinion should be done immediately after examination of the survivor on the basis of history and findings of detailed clinical examination of the survivor.
- It should be always kept in mind that normal examination findings neither refute nor confirm sexual violence. Hence circumstantial/other evidence may please be taken into consideration.
- Absence of injuries may be due to:
  - o Inability of survivor to offer resistance to the assailant because of intoxication or threats
  - o Delay in reporting for examination

The following are the components of a comprehensive health care response to sexual violence and must be carried out in all cases:



CONFIDENTIAL

Medico-legal Examination Report of Sexual Violence

1. Name of the Hospital ………………… OPD No. ……. Inpatient No ….......……………
2. Name ………………………………….. D/o or S/o (where known)…………..................…
3. Address……………………………………………..……………………………………………
4. Age (as reported) ……………………… Date of Birth (if known)……………………………
5. Sex (M/F/Others) ……………………………….……………..……….............……..…….
6. Date and Time of arrival in the hospital ……………………………………………….…….
7. Date and Time of commencement of examination……………………………..…………
8. Brought by………………………………………. (Name & signatures)
9. MLC No. …………………………………..Police Station……………………... …….……
10. Whether conscious, oriented in time and place and person………………………...……
11. Any physical/intellectual/psychosocial disability …………………………….….………

(Interpreters or special educators will be needed where the survivor has special needs such as hearing/speech disability, language barriers, intellectual or psychosocial disability.)

12. Informed Consent/refusal

I…………………………………………D/o or S/o………………………………………………

hereby give my consent for:

a) medical examination for treatment Yes ☐ No ☐

b) this medico legal examination Yes ☐ No ☐

c) sample collection for clinical & forensic examination Yes ☐ No ☐

I also understand that as per law the hospital is required to inform police and this has been explained to me.

I want the information to be revealed to the police Yes ☐ No ☐

I have understood the purpose and the procedure of the examination including the risk and benefit, explained to me by the examining doctor. My right to refuse the examination at any stage and the consequence of such refusal, including that my medical treatment will not be affected by my refusal, has also been explained and may be recorded. Contents of the above have been explained to me in ………………………. language with the help of a special educator/interpreter/support person (circle as appropriate) ………………………..……..

If special educator/interpreter/support person has helped, then his/her name and signature……………

Name & signature of survivor or parent/Guardian/person in whom the child reposes trust in case of child (<12 yrs)

…………………………………………
…………………………………………
…………………………………………

With date, time & place
Name & signature/thumb impression of Witness
…………………………………………
…………………………………………
…………………………………………

With Date, time and place

13. Marks of identification (Any scar/mole)
(1) ……………………………………………………………………
(2) ……………………………… ……………………………...

Left Thumb impression

14. Relevant Medical/Surgical history

Onset of menarche (in case of girls) Yes No Age of onset……………….....……
Menstrual history – Cycle length and duration ………...… Last menstrual period…........…

Menstruation at the time of incident - Yes/ No, Menstruation at the time of examination - Yes/ No

Was the survivor pregnant at time of incident - Yes/No, If yes duration of pregnancy ……… weeks

Contraception use: Yes/No……. If yes – method used: ……….......................................……

Vaccination status – Tetanus (vaccinated/not vaccinated), Hepatitis B (vaccinated/not vaccinated)

15 A.History of Sexual Violence

(I) Date of incident/s being reported	(ii) Time of incident/s	(iii) Location/s
(iv)Estimated duration : 1-7 days…….. 1 week to 2 months…………………………………….. 2-6 months………………. >6 months…………………………………………………………………… Episode: One…………. Multiple ……..……Chronic (>6 months) ……..Unknown……….		
(v) Number of Assailant(s) and name/s……………………………………………………………………………………… (vi) Sex of assailant(s)……………………………………………Approx. Age of assailant (s)………………………......... If known to the survivor – relationship with the survivor………………………………………………………………………………………………		
(vii) Description of incident in the words of the narrator: Narrator of the incident: survivor/informant (specify name and relation to survivor) ……………… If this space is insufficient use extra page		

15 B. Type of physical violence used if any (Describe):

Hit with (Hand, fist, blunt object, sharp object)	Burned with
Biting	Kicking
Pinching	Pulling Hair
Violent shaking	Banging head
	Dragging
Any other:	

15 C.

i. Emotional abuse or violence if any (insulting, cursing, belittling, terrorizing)………………..........................

ii. Use of restraints if any ………………………………………………………………………..

iii. Used or threatened the use of weapon(s) or objects if any……………………………………..

iv. Verbal threats (for example, threats of killing or hurting survivor or any other person in whom the survivor is interested; use of photographs for blackmailing, etc.) if any: ………………………………………...…………………………..

v. Luring (sweets, chocolates, money, job) if any: ……………..……………………………

vi. Any other:……………………………………………………………………………………..

15 D.

i. Any H/O drug/alcohol intoxication:

ii. Whether sleeping or unconscious at the time of the incident: …………….………………

15 E. If survivor has left any marks of injury on assailant/s, enter details: ……………………

15 F. Details regarding sexual violence:

Was penetration by penis, fingers or object or other body parts (Write Y=Yes, N=No, DNK=Don't know) **Mention and describe body part/s and/or object/s used for penetration.**

	Penetration			Emission of Semen		
Orifice of Victim	By Penis	By body part of self or assailant or third party (finger, tongue or any other)	By Object	Yes	NO	Don't know
Genitalia (Vagina and/or urethra)						
Anus						
Mouth						

Oral sex performed by assailant on survivor	Y	N	DNK
Forced Masturbation of self by survivor	Y	N	DNK
Masturbation of Assailant by Survivor, Forced Manipulation of genitals of assailant by survivor	Y	N	DNK
Exhibitionism (perpetrator displaying genitals)	Y	N	DNK
Did ejaculation occur outside body orifice (vagina/anus/mouth/urethra)?	Y	N	DNK

If yes, describe where on the body			
Kissing, licking or sucking any part of survivor's body	Y	N	If Yes, describe
Touching/Fondling	Y	N	If Yes, describe
Condom used*	Y	N	DNK
If yes status of condom	Y	N	DNK
Lubricant used*	Y	N	DNK
If yes, describe kind of lubricant used			
If object used, describe object:			
Any other forms of sexual violence			

*** Explain what condom and lubricant is to the survivor**

Post incident has the survivor	Yes/No/Do Not know	Remarks
Changed clothes Changed undergarments Cleaned/washed clothes Cleaned/washed undergarments Bathed Douched Passed urine Passed stools Rinsing of mouth/Brushing/ Vomiting (Circle any or all as appropriate)		

Time since incident………………………………………………………………………. H/o vaginal/anal/oral bleeding/discharge prior to the incident of sexual violence………………

H/o vaginal/anal/oral bleeding/discharge since the incident of sexual violence…………..…..

H/o painful urination/ painful defecation/ fissures/ abdominal pain/pain in genitals or any other part since the incident of sexual violence

16. General Physical Examination-

i. Is this the first examination……………………………………………...………………….

ii. Pulse………. …………………………… BP……………………………………….……….

iii. Temp.………………………………………….Resp. Rate…………………….……………

iv. Pupils ……………………………………………………………………………….…….

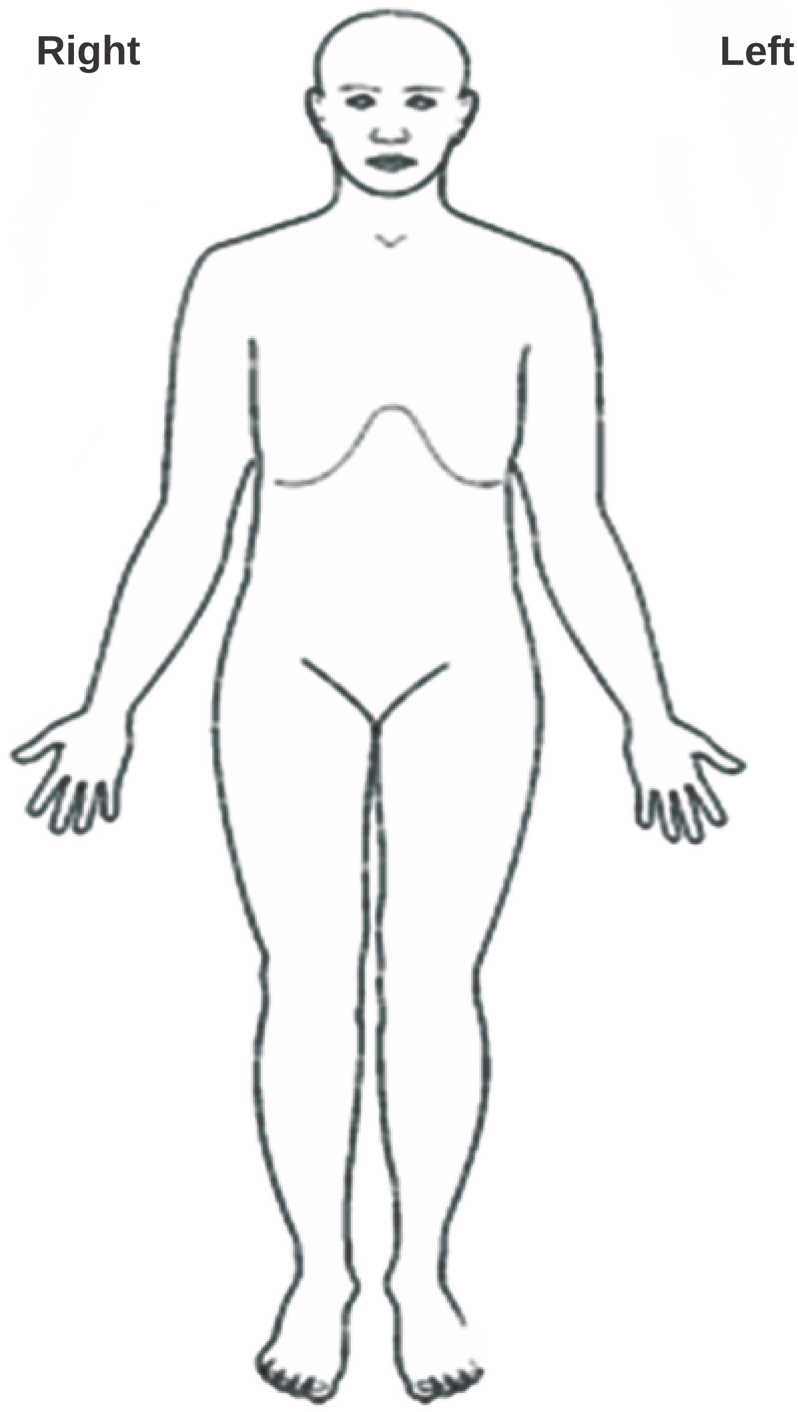
v. Any observation in terms of general physical wellbeing of the survivor………………..

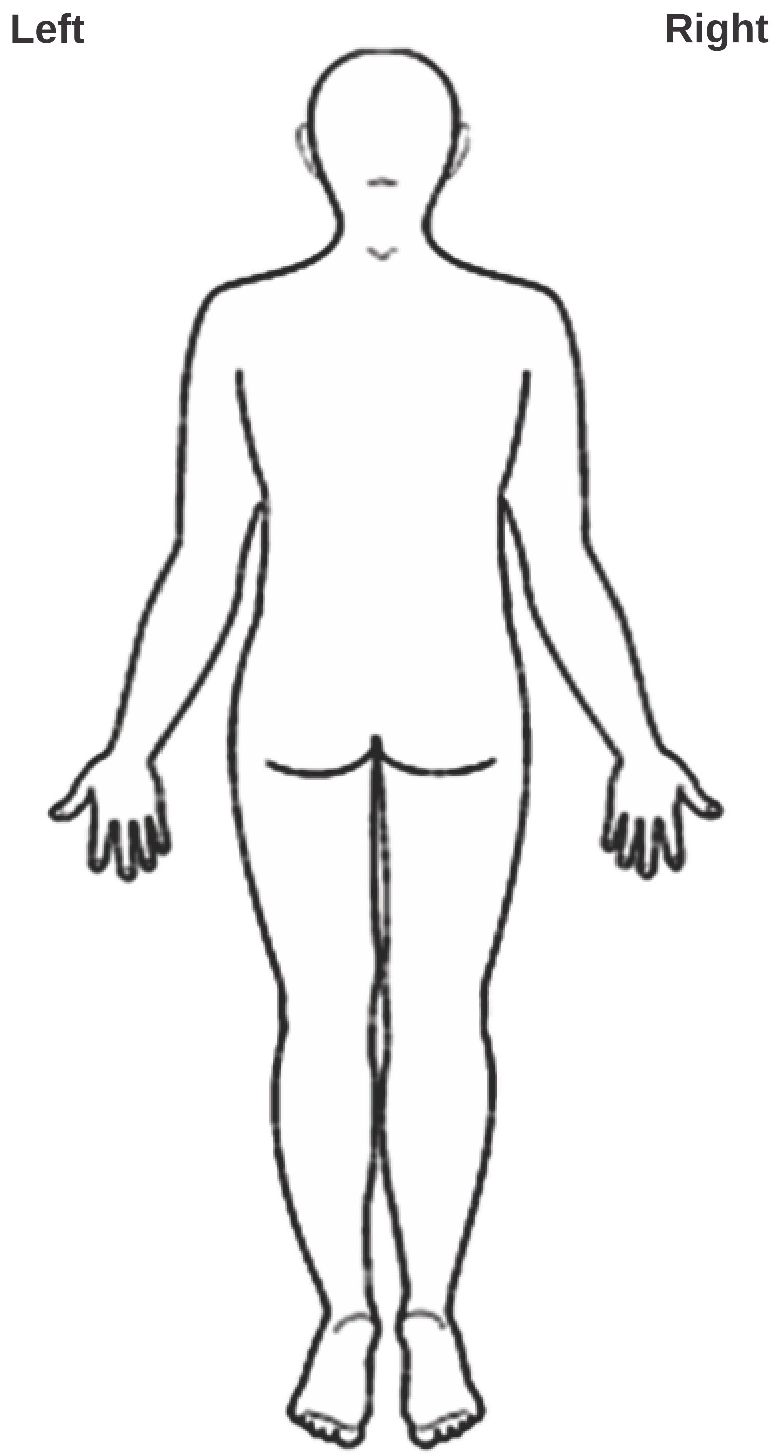
17. **Examination for injuries on the body if any**

The pattern of injuries sustained during an incident of sexual violence may show considerable variation. This may range from complete absence of injuries (more frequently) to grievous injuries (very rare).

(Look for bruises, physical torture injuries, nail abrasions, teeth bite marks, cuts, lacerations, fracture, tenderness, any other injury, boils, lesions, discharge specially on the scalp, face, neck, shoulders, breast, wrists, forearms, medial aspect of upper arms, thighs and buttocks) Note the Injury type, site, size, shape, colour, swelling signs of healing simple/grievous, dimensions.)

Scalp examination for areas of tenderness (if hair pulled out/ dragged by hair)	
Facial bone injury: orbital blackening, tenderness	
Petechial haemorrage in eyes and other places	
Lips and Buccal Mucosa / Gums	
Behind the ears	
Ear drum	
Neck, Shoulders and Breast	
Upper limb	
Inner aspect of upper arms	
Inner aspect of thighs	
Lower limbButtocks	
Other, please specify	


Right
Left


Left
Right

18. Local examination of genital parts/other orifices*:

A. External Genitalia: Record findings and state NA where not applicable.

Body parts to be examined	Findings	
Urethral meatus & vestibule		
Labia majora		
Labia minora		
Fourchette & Introitus		
Hymen Perineum		
External Urethral Meatus		
Penis		
Scrotum		
Testes		
Clitoropenis		
Labioscrotum		
Any Other		

*** Per/Vaginum /Per Speculum examination should not be done unless required for detection of injuries or for medical treatment.**

P/S findings if performed ………………………………………………………………………

P/V findings if performed ………………………………………………………………………

Record reasons if P/V of P/S examination performed …………………………………………

C. Anus and Rectum (encircle the relevant)

Bleeding/ tear/ discharge/ oedema/ tenderness

D. Oral Cavity - (encircle the relevant)

Bleeding/ discharge/ tear/oedema/ tenderness

19. Systemic examination:

Central Nervous System: ……………………………………………………………………….

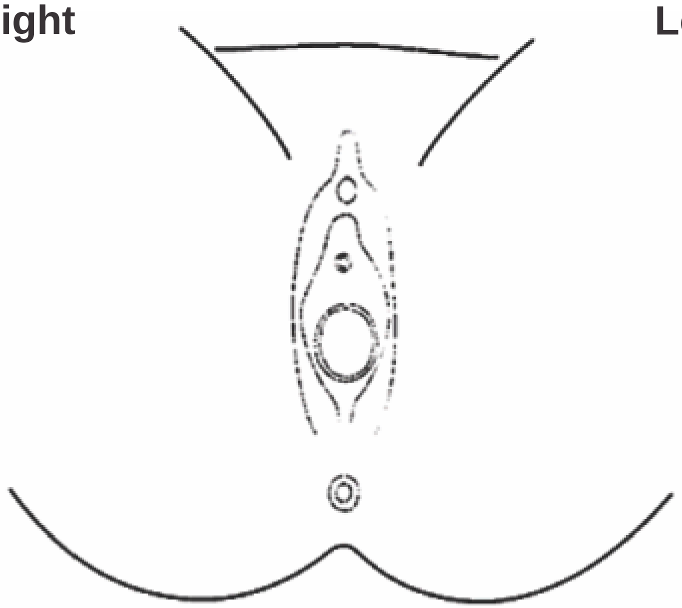
Cardio Vascular System: ……………………………………………………………………….

Respiratory System: ………………………………………………………………………….

Chest: …………………………………………………………………………………………..

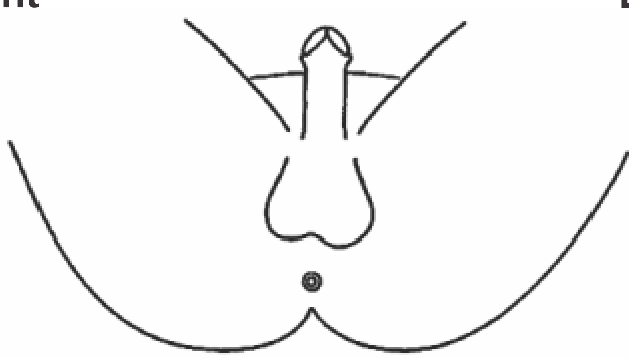
Abdomen: ……………………………………………………………………………………....

Right Left





Right Left



20. Sample collection/investigations for hospital laboratory/ Clinical laboratory

1) Blood for HIV, VDRL, HbsAg
2) Urine test for Pregnancy/
3) Ultrasound for pregnancy/internal injury
4) X-ray for Injury

21. Samples Collection for Central/ State Forensic Science Laboratory

1) Debris collection paper
2) Clothing evidence where available – (to be packed in separate paper bags after air drying)

List and Details of clothing worn by the survivor at time of incident of sexual violence

3) Body evidence samples as appropriate (duly labeled and packed separately)

	Collected/Not Collected	Reason for not collecting
Swabs from Stains on the body (blood, semen, foreign material, others)		
Scalp hair (10-15 strands)		
Head hair combing		
Nail scrapings (both hands separately)		
Nail clippings (both hands separately)		
Oral swab		
Blood for grouping, testing drug/alcohol intoxication (plain vial)		
Blood for alcohol levels (Sodium fluoride vial)		
Blood for DNA analysis (EDTA vial)		
Urine (drug testing)		
Any other (tampon/sanitary napkin/condom/object)		

4) **Genital and Anal evidence** (Each sample to be packed, sealed, and labeled separately-to be placed in a bag)

* Swab sticks for collecting samples should be moistened with distilled water provided.

	Collected/Not Collected	Reason for not collecting
Matted pubic hair		
Pubic hair combing (mention if shaved)		
Cutting of pubic hair (mention if shaved)		
Two Vulval swabs (for semen examination and DNA testing)		
Two Vaginal swabs (for semen examination and DNA testing)		
Two Anal swabs (for semen examination and DNA testing)		
Vaginal smear (air-dried) for semen examination		
Vaginal washing		
Urethral swab		
Swab from glans of penis/clitoropenis		

*Samples to be preserved as directed till handed over to police along with duly attested sample seal.

22. Provisional medical opinion

I have examined (name of survivor).............M/F/Other.................aged............................. reporting_ (type of sexual violence and circumstances)..................., XYZ days/hours after the incident, after having (bathed/douched etc)....................... My findings are as follows:

- Samples collected (for FSL), awaiting reports
- Samples collected (for hospital laboratory)
- Clinical findings
- Additional observations (if any)

23. Treatment prescribed:

Treatment	Yes	NO	Type and comments
STI prevention treatment			
Emergency contraception			
Wound treatment			
Tetanus prophylaxis			
Hepatitis B vaccination			
Post exposure prophylaxis for HIV			
Counselling			
Other			

24. Date and time of completion of examination ……………………………....……………

This report contains ……………………….. number of sheets and ……………………..…… number of envelopes.

Signature of Examining Doctor

Name of Examining Doctor

Place: Seal

25. Final Opinion (After receiving Lab reports)

Findings in support of the above opinion, taking into account the history, clinical examination findings and Laboratory reports of …………………… bearing identification marks described above, …………………………. hours/ days after the incident of sexual violence, I am of the opinion that:

Signature of Examining Doctor

Name of Examining Doctor

Place: Seal

COPY OF THE ENTIRE MEDICAL REPORT MUST BE GIVEN TO THE SURVIVOR/ VICTIM FREE OF COST IMMEDIATELY